STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 16, 17, 18, 19, 20, 21, 22, 23, and 24, 2011 Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530 Survey Team: Sandra Haws, RN TC - May 16, 17, 18, 19, 20, 23, and 24, 2011 Toni Krakowski, RN Vicki Manuwal, RN Bobbi Costigan, RN- May 16, 17, 18, 19, 20, 23, and 24, 2011 Census Bed Type: SNF/NF: 94 Total: 94 Census by Payor Type: Medicare: 6 Medicaid: 73 Other: 15 Total: 94 Sample: 19 Supplemental Sample: 30 These deficiencies also reflect state	F0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2 Quality review completed on June 1, 2011 by Bev Faulkner, RN			

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F0157 SS=E	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview, and record review, the facility failed to ensure the physician was notified of changes related to inadequate pain control (Resident #40), weight loss (Resident #54), elevated blood sugars (Residents #80 and #3), and respiratory decline (Resident #27) for 5 of 5 residents	F0157	**F-157** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: Resident #40 received her scheduled norco at	06/23/2011

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	reviewed for clinical changes in a sample of 19. Findings include: 1. Resident #40's clinical record was reviewed on 5/16/11 at 2:35 P.M., and indicated diagnoses of, but not limited to: history of sacral/pelvic fracture, osteoporosis, macular degeneration, senile dementia, and osteoarthritis of the hips. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, Resident #40 was observed lying in her bed. The resident was grimacing and indicated she was having pain at the time. LPN #2 indicated the resident had a recent fall and sustained an irreparable fractured right hip. Resident #40 was observed on 5/16/11 at 12:25 P.M., screaming out in pain when she was pulled up in her bed by LPN #2 and CNA #5. During interview with LPN #2 at the time, she stated, "We need to get some of the PRN (Norco) in her." A Physician's Order, dated 5/4/11 at 1:20 P.M., indicated, "Norco 5/325 (Hydrocodone 5mg [milligram]-325 mg APAP [acetaminophen]) tablets. Give i (one) PO (by mouth) TID (three		14:50 on 5/16/11, therefore no notification was required for ongoing pain. The physician has been notified for resident #54 related to decreased appetite and subsequent weight loss with new orders received. The physician has been notified for resident #27 related to resident's condition with no new orders received. The physician was notified for resident #3 on 03/26/11 and 3/27/11 related to elevated blood sugars and orders received for insulin administration. Resident received additional insulin at the time per physician order. The physician has been notified for resident #80 relative to elevated blood sugar with no new orders received. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:A facility wide audit of all medical records for the last 30 days has been conducted to evaluate compliance with notification of family and physician related to change in condition. Any identified concerns lacking notification have resulted in appropriate notifications being made. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Licensed nursing staff has been in-serviced related to physician notification regarding change of condition by the Staff Development Coordinator. *To ensure the deficient practice does*	

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	times/day) 6 A.M., 2 P.M., 10 P.M. Keep PRN (as needed) Norco order (every 4 hours) for breakthrough pain...." Resident #40 also had an order for Acetaminophen (over the counter analgesic) 650 mg. TID and Tramadol 100 mg. TID. Review of Resident #40's Medication Administration Record (MAR) on 5/16/11 at 12:30 P.M., indicated she had been medicated with Norco (narcotic pain medication) 5 mg. (milligram) at 6:00 A.M. (scheduled dose)with the next scheduled dose of Norco to be administered at 2:00 P.M. She received 650 mg. of acetaminophen (over-the-counter analgesic) and 100 mg. of Tramadol (non-narcotic pain medication) at 8:00 A.M. Further review of the MAR indicated LPN #2 medicated Resident #40 with the PRN (as needed) Norco 5 mg. at 12:30 P.M. for her breakthrough pain. On 5/16/11 at 4:50 P.M., Resident #40 indicated in an interview she was having "bad" pain in her right hip and was fearful of being moved in bed. Review of her MAR, at the time, indicated she had not been given her 2:00 P.M. scheduled dose of Norco, but had received another dose of the 650 mg. acetaminophen and 100 mg. of the Tramadol at 2:00 P.M. She		*not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with physician notification. The Director of Nursing or designee will complete the indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	received a PRN dose of Norco at 4:00 P.M. Review of Nurse's Notes indicated the following: "5/2/11 at 2:00 P.M.-Up with assist of one with walker to meals and BR (bathroom)...5/3/11 at 9:30 P.M.-Res. was sitting in Dayroom. Disengaged her Mobility Monitor. Observed standing in Dayroom got up to go to rm (room). Res. lost bal (balance) et (and) fell to floor on R side...5/4/11 at 8:30 P.M.-Res. crying out in pain, grabbing R hip. Norco given after repositioning. Unsuccessful...c/o's (complains of) pain with turning to change pads...agitated with staff while turning. Pain #8-#9 (pain scale 0-10 with 10 being 'worst pain that can be imagined') when moving...5-5-11 at 7:30 P.M.-...Medicated for pain #9 at 6P (P.M.) with Norco...in severe pain when T & R (turned and repositioned)...5-6-11 at 9:00 P.M.-...Cries out loudly grabbing at staff members in severe pain whenever being T & R or ever putting HOB (head of bed) up or down...5/7/11 at 10:50 P.M.-T & R q (every) 2 hours-cries out loudly, grabbing staff arms and clothing-severe pain when being T & R...5/8/11 at 2:00 P.M.-...much discomfort when moved feet up...medicated x 1 between routine Norco dose...5/8/11 at 8:00 P.M.-...cont. (continues) to be in severe pain when			

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	turned despite pain meds...5/9/11 at 3:53 A.M.-...Cont. to show s/s (signs and symptoms) of pain when moved. PRN medication given...5/9/11 at 1:45 P.M. -...when res. turned yells out at staff, facial grimacing...5/9/11 at 6:19 P.M. -...yells out with P.M. care, routine and PRN meds given...5/10/11 at 2:00 P.M. -...as long as still no pain on routine pain med...5/11/11 at 2:00 P.M.-...much discomfort when turned...5/11/11 at 9:30 P.M.-...severe pain when care is being given...5/12/11 at 3:50 P.M.-...cont. in pain when T & R...5/12/11 at 7:50 P.M. -...Medicated for pain #9 at 1800 (6:00 P.M.) with some relief obtained-cont. to moan-cry out, tear at staff's clothing when being T & R...5/13/11 at 6:30 A.M. -...Repositioned and changed and the c/o's of Rt (right) hip pain with care...5/13/11 at 2:25 P.M.-...Res. yell (sic) out some in pain when turned or repositioned by ii (2) assist...5/14/11 at 6:00 A.M.-...Resists being turned due to increased Rt leg pain with movement...5/14/11 at 9:22 P.M. -...severe pain when T & R (moaning, crying out, tearing at clothing)...5/15/11 at 7:30 P.M.-...uncomfortable when T & R...5/16/11 at 2:50 P.M.-...Routine pain meds as ord. (ordered), during repositioning after lunch res. pulled up in bed, yelling out, "My leg, No No," was given PRN med at 12:30 with lunch then routine pain meds at 1400 (2:00 P.M.) et			

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	Norco routine at 1450 (2:50 P.M.), during incont. (incontinence) care et repositioning seemed much more comfortable...5/17/11 at 2:00 A.M. -...Yelling out with pain...." The Nurse's Notes lacked documentation to indicate the physician had been notified of the ongoing pain. During interview with Resident #40 on 5/17/11 at 9:10 A.M., she indicated she was having pain in her right hip, but was unable to rate her pain on the 0-10 pain scale. The MAR indicated a Norco 5 mg. had been given to Resident #40 at 6:00 A.M. Nurse's Notes indicated, "5/17/11 at 3:45 P.M.-...Yells out when moved...5/17/11 at 9:45 P.M.-Resident has lots of pain with any movement...." The Director of Nursing (D.O.N.) indicated in an interview on 5/18/11 at 11:15 A.M., a Physician's Order had been obtained for Morphine Sulfate (a strong, fast-acting pain narcotic) 5 mg. to be administered every two hours for breakthrough pain. "The Vicodin (Norco) wasn't controlling her pain. We were using the PRN Vicodin, but it wasn't doing the job. We just gave her a dose of the morphine to help control her pain. We are going to reposition her in about 30-35			

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	minutes to see how she does." During observation of Resident #40 on 5/18/11 at 11:35 A.M., CNA #15 and the D.O.N. were observed providing incontinence care. CNA #15 reached across the bed, grabbed Resident #40's right femur (large thigh bone) and pulled Resident #40 towards her while the D.O.N. pushed on Resident #40's right hip to aid in turning her onto her left hip. Resident #40 moaned slightly, but did not scream out in pain. CNA #12 and CNA #14 were observed providing incontinence care to Resident #40 on 5/19/11 at 1:10 P.M. Resident #40 moaned when the head of her bed was lowered to a flat position and screamed out in pain when her legs were touched. Resident #40 was rolled onto her right hip so she could be washed. She screamed out in pain as she was rolled. CNA #14 then reached across the bed and pulled on Resident #40's right thigh while CNA #12 pushed on her right hip to turn her over onto the left hip. Resident #40 screamed out in pain and yelled "My leg. My leg." During interview with the D.O.N. on 5/19/11 at 1:35 P.M., she indicated staff wanted to control Resident #40's pain, but did not want to "snow" her. When queried why the doctor had not been notified of			

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	the situation, the D.O.N. indicated she was going to consult a "palliative care" physician to evaluate Resident #40 and suggest treatment to control her pain. Resident #40's Care Plan, dated 5/10/11, indicated, "Problem: Fracture: Right Hip Resident Fall. Goal: Resident will have no complications and minimal pain from hip fracture. Approach: ...Administer pain medication as ordered and check for effectiveness and notify doctor if resident not getting relief...." 2. Resident #54's record was reviewed on 5/18/11 at 8:50 a.m. The resident's record indicated diagnoses of, but not limited to; right cerebral vascular accident, dementia, osteoporosis and cardiomegally. The Resident's weights for the month of January 9th, 2011 was 141 pounds. February 9th, 2011's weight was 155.2. March 6th, 2011 weight was 156.7 pounds. April 2011 weight was 155.5, and May 2011 weight was 128.5. The resident's reweight for May was recorded at 126.9 pounds. The weight loss calculated at 28.6 pounds lost from April to May, 2011. Nurses notes, dated 4/17/11 to 5/15/2011, lacked documentation indicating the physician had been notified of the			

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	significant weight loss for May. The Resident's form titled "Individual Resident Meal Intake Record," dated April 2011, indicated from April 9th to the 15th, the resident had refused her supper and also the alternate. The resident's record lacked documentation to indicate the dietitian or the physician had been notified. On April 28th the form indicated Resident # 54 refused all three meals that day. The April meal intake form indicated for the entire month of April, her intake was less than 25% with refusal of many of the meals and alternates. The nurses notes lack documentation to indicate the physician or the dietitian had been notified. The Resident's plan of care, dated 3/15/10, indicated "Problem: Significant weight loss (March 2010) Leaves 25% or more uneaten most meals, at risk for choking Dx (diagnosis) Hiatal Hernia, Dx: Dysphagia...Approach:...Notify RD and MD of significant weight changes...." During an interview with the Director of Nursing on 5/19/11 at 5:20 p.m. regarding the lack of the physician being notified of the significant weight loss, she indicated she was not aware he was not notified or			

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	why he was not notified, but indicated he should have been made aware right away. A facility policy titled "Nutritional Risk, Nutritional Problem and/or Significant Change," dated 10/31/10, indicated "...7. Notify and consult with physician regarding patient's current nutritional status or significant change in nutritional status...." 3. Resident #27's record was reviewed on 5-16-2011 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. On 5/16/2011 at 6: a.m., Resident #27 was observed during tour with a tracheotomy and oxygen at 4 liters via a tracheotomy mask. On 5/16/2011 at 6:11 p.m., RN # 6, RN #7, RN #8 and the ADON (Assistant Director of Nursing) were observed providing care to Resident # 27. Once care was completed, all the staff except the ADON left the room. At 6:30 p.m., a large amount of mucus was noted inside of the outer cannula of the tracheotomy. The ADON was asked to lift the sheet to allow observation of the nail beds. Resident #27's nail beds were			

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	blue/gray in color and the fingers were mostly blue in color. Resident #27 was also noted to be experiencing a violent cough. The inner lumen of the oxygen tubing was noted to be completely obstructed with mucus. At 6:42 p.m., RN #8 was requested to return to the room with a biox (to test blood oxygen levels), Resident # 27's biox was 84%. At 6:49 p.m., RN #8 brought suction equipment to room. Resident #27 observed coughing and gagging. At 6:54 p.m., Resident #27's biox is 87%, oral mucus secretions visualized, Resident #27 was observed gagging. At 6:57 p.m., The biox was 86%, mucus was observed gurgling from resident's mouth. At 7:11 p.m., Suction equipment brought to Resident #27's room and was coughing violently, gagging, and flailing forward in bed. Biox was 89%. RN #8 indicated that he does not know this man, and he had only been on this floor for a couple of weeks. At 7:13 p.m., Biox up to 89%, DON now to resident's room. Requested different biox to compare results. At 7:18 p.m., Different biox brought to room, Resident #27's biox was then 93%. Resident was then cleaned and repositioned in bed.			

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	A review of the "Comprehensive Care Plan Report" indicated that "...Problem...At risk for respiratory distress...Goal...Will have no or minimal Respiratory Distress...Approach...Oxygen as ordered, monitor & report s/sx (signs and symptoms) of shortness of breath, labored breathing and/or cyanosis (lack of oxygen), measure oxygen saturation as ordered, Lung assessment as ordered and prn (as needed)...suction as needed...Keep Physician and Family informed as needed...." The "Treatment Record" for May of 2011 stated, "...Oxygen to trach (tracheotomy) mask to maintain oxygen saturation 90% or greater...." The "Medication Record" dated May 2011 stated, "...May suction oral cavity as needed...." The "Medication Record" dated May 2011 stated, "...May suction trach prn (as needed) for increase secretions...." The "Medication Record" dated May 2011 stated, "...O2 (oxygen) to trach to keep O2 saturation greater than 90%...." On 5/17/11 at 7 p.m., RN #8 indicated that Resident #27 experienced a decline in respiratory function on 5/16/11 from 6:11			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

p.m. until 7:18 p.m. RN #8 indicated a respiratory assessment was not completed prior to suctioning or immediately after this incident by staff to determine lung function/sounds. RN #8 also indicated the physician should have been notified.

4. Resident #3's record was reviewed on 5-19-2011 at 2:00 p.m. Resident #3's diagnoses include, but were not limited to, Diabetes Mellitus and dementia.

The "Medication Record" for the month of March stated, "...Sliding scale, if blood sugar 0-150= 0 units, 151-200= 3 units, 201-250= 6 units, 251-300= 9 units, 301-350= 12 units, 351-400= 14 units, call MD if blood sugar less than 60 or greater than 400...."

The "Medication Record" on 3/26/11 at 4 p.m., indicated the blood sugar was 483. There was no documentation supporting that MD was notified.

The "Medication Record" on 3/27/11 at 4 p.m., indicated the blood sugar was 420. There was no documentation supporting that MD was notified.

An interview was conducted on 5/19/2011 at 4:25 p.m., with LPN #3. LPN #3 indicated that when an MD is notified the Resident Progress Notes would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

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	updated. LPN #3 looked for notification regarding the blood sugars on 3/26/11 and 3/27/11 and was unable to find any documentation. The policy titled, "Notification" dated 10/31/07 was reviewed on 5/24/11 at 2:00 p.m. stated, "...Staff informs the resident, consults with their attending physician, and notifies the resident's surrogates when:...A significant change occurs in the resident's physical, mental, psychosocial status...Compliance Guidelines...2. If the family has designated a member to receive calls, that individual is notified when notifications are required, unless precluded by a competent resident's instructions...." 5. The clinical record for Resident # 80 reviewed on 5/16/11 at 10:45 A.M., indicated diagnoses of, but not limited to, diabetes mellitus, acute kidney failure, and peripheral neuropathy. A Physician Order, dated 2/5/11, indicated, "...Glucometers twice daily...Sliding Scale. If blood sugar 60-150=0 units, 151-200=4 units, 201-250=8 units, 251-300=12 units, 301-350=14 units, 351-400=16 units, Call			

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	MD if blood sugar less than 60 or greater than 350...." Review of the February 2011, MAR (Medication Administration Record) indicated, Resident # 80's blood sugar on 2/17/11 at 1600 (4:00 P.M.) was 368. Review of the April 2011, MAR indicated, the 1600 blood sugar on 4/3/11 was 356. Review of the clinical record lacked documentation of doctor notification. Resident # 80's Care Plan, dated 5/19/11, indicated, "...Keep Physician...informed as needed..." Interview on 5/20/11 at 9:15 A.M., the ADON (Assistant Director of Nursing) indicated the physician should have been notified of the above blood sugar results. A facility policy titled "Notifications," revised 10/31/10, indicated, "...Staff...consults with their attending physician...when...a significant change occurs in the resident's physical, mental or psychosocial status...Treatment needs to be altered significantly..." 3.1-5(a)(2)			

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F0166 SS=D	A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on observations, interviews and record review, the facility failed to ensure grievances had been addressed related to odors, dirty and cluttered halls for 2 of 2 grievance's filed by 1 of 1 resident family in a supplemental sample of 30. Resident # 52. Findings include: 1. Review of the facility grievance records on 5/18/11 at 2:45 p.m., indicated the following grievance was expressed by Resident # 52's family on 10/8/10. The grievance indicated "...strong urine smell in MDR (main dining room)...floors in hallways dirty...." Resident # 52's record was reviewed on 5/24/11 at 11:00 a.m. The resident's record indicated diagnoses of, but not limited to;'s Alzheimer's disease, diabetes, cardiac dysrhythmias, and urinary incontinence. During a tour of the facility's north and south dining rooms on May 16th 2011 at 6:00 p.m., a urine odor was detected in both dining areas. There was a strong	F0166	**F-166** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:*The corrective action taken for the residents found to have been affected by the deficient practice was*:The family of resident #52 and members of the Resident Council were notified of action steps taken to resolve the grievance surrounding odor on 6/14/11. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:All grievances received in the last 30 days have been reviewed for appropriate resolution and follow-up. Any unresolved issues have had additional steps taken to ensure satisfaction and resolution to any voiced concerns. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*:Facility staff has been in-serviced on the grievance procedure and follow up when a resident or family member has a concern. All staff was in-serviced on the location of the grievance forms. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been	06/23/2011

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	urine odor throughout the facility the entire day from 6:30 a.m. until 9:00 p.m. The halls on the north and south areas of the facility were observed to be cluttered with bedside tables, Hoyer lifts, trash barrels, housekeeping supplies, and walkers. The wheelchairs were lined up all along the side of the halls on both units, north and south. Medication carts were observed along the halls amongst the other items on both units. The hall floors were observed to be soiled with dirt debris. During a group meeting on 5/17/11 at 10:30 a.m., with 10 alert and oriented residents, they all complained of the hallways in the facility being cluttered impeding their wheelchair mobility at times. Observation was made on 5/18/11 at 7:10 a.m., of a resident having trouble maneuvering his wheelchair down the hall when other residents pass by due to the hall clutter. Review of another grievance reported by Resident # 52's family dated 2/1/11 indicated "...says smell is horrible (eyes burn when visiting d/t (due to) urine smell so bad) says (name) stated "this will never happen" says husband (name) doesn't even want to come d/t "it's horrible here."		established which evaluates compliance with the grievance process. Executive Director or designee will complete the indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	155474	A. BUILDING 00 B. WING	05/24/2011

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	Says "they just are not getting good care, doesn't know what is going on here...." The grievance report, dated 10/8/10, indicated the following to resolve the grievance; "Spoke with (name) who was the nurse in MDR (main dining room) to keep a closer eye on what is happening in the dining room. Spoke with (name) about upcoming weekend manager add to Oct (October) Nursing meeting." The grievance resolution documented for the hall clutter indicated "...Hallways be cleared today by floor tech." During an interview on 5/18/11 at 10:30 a.m., with a family member who wished to remain anonymous, complained about the urine smell in her mother's room. She indicated it was so strong they had to remove both mattresses in the room to get rid of the urine odor. She also indicated that her mother smelled of body odors. During an interview with the Administrator on 5/18/11 at 11:45 a.m., regarding the strong urine odors throughout the facility, he indicated he could not smell them. The strong urine odor was present throughout the facility on the following dates and times for 2011;			

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	May 16th from 6:30 a.m. until 9:00 p.m. May 17th from 8:30 a.m. until 5:00 p.m. May 18th from 6:45 a.m. until 7:10 p.m. May 19th from 8:10 a.m. until 5:15 p.m. May 20th from 8:30 a.m. until 7:15 p.m. and May 23rd from 8:00 a.m. until 6:30 p.m. The facility's policy titled "Complaints/Grievance" dated 10/31/10 indicated "...12. Conduct on-going follow up to validate resolution is maintained and the resident and family member/responsible party's are satisfied with the resolution...." 3.1-7(a)(2)			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review, the facility failed to ensure a resident was kept free from restraints related to the facility using a recliner as a restraint to keep the resident from freely moving about the facility for 1 of 1 residents reviewed for restraints in a sample of 19. Resident: #35 Findings include:	F0221	**F-221** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:Resident has an ongoing and long term preference to use the recliner for periods of rest and night time sleeping. A restraint assessment was completed for resident #35. The plan of care was updated to	06/23/2011

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	Resident #35's clinical record was reviewed on 5/19/11 at 10:45 A.M., and indicated diagnoses of, but not limited to: Alzheimer's dementia with behavioral disturbance, bipolar disorder, and delusional disorder. Resident #35 was admitted to the facility on 11/22/10. During initial tour of the facility on 5/16/11 at 7:00 A.M., while accompanied by LPN #2, she indicated Resident #35 had behaviors, was confused, and was a two person assist. He was observed sitting in a recliner in the central living area of the dementia unit. The recliner was tipped back and the footrest was fully extended out. Resident #35's feet dangled off to the side. Resident #35 was again observed on 5/16/11 at 11:55 A.M., sitting in the same recliner in the central living area of the dementia unit. His recliner was tipped back with the footrests fully extended and his legs dangling off to the left side. He was leaning forward and attempting to rise from the chair, but was unsuccessful because of the positioning of the recliner. His sweat pants were wet, as he was incontinent of a large amount of urine. During interview with the Social Service/Director on 5/16/11 at 11:58		reflect the presence of the recliner as a restraint. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:A facility wide audit was conducted to evaluate all assistive devices currently in place to ensure that any other potential restraints have been identified, assessed and care planned as needed. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*:Nursing staff has been in-serviced on resident positioning, the definition of a restraint and appropriate assessment completion. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with restraints and assessing for restraints. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	P.M., she indicated meals would be arriving and she would ensure Resident #35 would be cleaned up for lunch. CNA #5 and LPN #2 were observed assisting Resident #35 to the bathroom five minutes later and changed his clothing. Resident #35 was observed later that day at 2:30 P.M., in the same recliner in the same position. He was, again, trying to rise from the recliner and was unable to do so because of the elevated footrest and reclined position of the chair. Other residents in the area were engaged in activities, but Resident #35 did not appear interested in the ongoing activities. On 5/18/11 at 4:25 P.M., Resident #35 was observed in the recliner in the central living area of the dementia unit. The recliner was tipped back with the footrest fully extended. He had his socks and shoes off and his bare feet dangled off to the left side of the footrest. He was attempting to put a rolled up magazine into one of the socks he had removed. His pants were soiled with urine. During interview with Social Service/Director on 5/18/11 at 4:40 P.M., she indicated Resident #35 needed supervision because of his behaviors. Review of Resident #35's quarterly MDS			

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	(Minimum Data Set) Assessment, dated 4/06/11, indicated he was ambulatory with one person assist. The Director of Nursing indicated in an interview on 5/19/11 at 5:00 P.M., the facility was not using the recliner as a restraint, therefore, a care plan was not in place and the MDS Assessment did not indicate Resident #35 had a restraint. A facility policy titled "Restraints," revised 4/28/09, indicated, "Policy: The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Definitions-Physical Restraints: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement...1. Physical restraints include, but are not limited to: ...c. Placing a resident in a chair that prevents a resident from rising...." 3.1-3(w)			
F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			

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	Based on observations, interviews, and record review, the facility failed to ensure residents' dignity related to: urinary incontinence (Residents: #35, #49, #3), display of red biohazard barrels in a resident's room (Resident #87), and residents with facial hair (Residents: #20, #51, #58, #60), and residents left sitting idle and unengaged in the hallway of the south unit(Resident #91, #59, #75, #70, #85, #54, #53, #68, #69, #55, #84) and in the North Unit lounge (Residents #7, #17, #21, #12, #8, # 3, # 32, #9, # 6, and # 18.) This deficient practice affected 4 of 19 in the sample of 19 and 24 of 30 in the supplemental sample of 30 reviewed for dignified care. Findings include: 1. Resident #35's clinical record was reviewed on 5/19/11 at 10:45 A.M., indicated diagnoses of, but not limited to: Alzheimer's dementia with behavioral disturbance, bipolar disorder, and delusional disorder. During initial tour of the facility on 5/16/11 at 7:00 A.M., while accompanied by LPN #2, she indicated Resident #35 had behaviors, was confused, incontinent, and a two person assist. Resident #35 was observed on 5/16/11 at	F0241	**F-241** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:Residents #20, #51 and #58 facial hair grooming issues were resolved during the course of the survey. Resident #60's preferences related to retaining facial hair will be honored. The red barrels in the room of resident #87 were removed during the survey and offered an apology. Residents #3, #35, and #49 were provided incontinence care and wheel chairs and cushions cleaned during the course of the survey. Residents #91, #59, #75, #70, #85, #54, #53, #68, #69, #55, #84, #7, #17, #21, #12, #8, #3, #32, #9, #6 and #18 were re-evaluated related to functional status and participation in activity programming. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:The facility validated that residents are free of unwanted facial hair. All rooms were audited for unnecessary medical equipment and items removed as needed. All residents are being monitored for appropriate and timely incontinence care to prevent personal hygiene from being compromised and/or	06/23/2011

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	11:55 A.M., sitting in a recliner in the central living area of the dementia unit. His sweat pants were wet, indicating he was incontinent of a large amount of urine. During observation of a medication administration pass on 5/16/11 at 5:20 P.M., LPN #29 indicated Resident #35 was in the bathroom. She opened the door of the restroom, which was located immediately off of the dining room. Two visitors had full view of the bathroom commode on which Resident #35 was seated with his pants down. On 5/18/11 at 4:25 P.M., Resident #35 was observed in the recliner in the central living area of the dementia unit. He had his socks and shoes off and his bare feet dangled off to the left side of the footrest. His pants were soiled with urine. During interview with Social Service/Director on 5/18/11 at 4:35 P.M., she indicated she could not toilet Resident #35 by herself and the other staff person was busy with other residents. 2. During initial tour of the dementia unit on 5/16/11 at 7:00 A.M., while being accompanied by LPN #2, Resident #49 was observed in her room. She was identified as being incontinent. She night		equipment becoming soiled. All residents in the center were evaluated related to functional status and activity programming modified to enhance offerings for all functional levels. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*:Nursing staff has been in-serviced related to grooming, provision of incontinence care, and storage of isolation equipment. Activity Director has been in-serviced related to enhance programming for all functional levels. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with grooming/facial hair, incontinence care, personal device cleanliness, rooms free from unnecessary medical/storage equipment and activity programming for dependent residents. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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clothes and all of her bed linens were urine soaked, at the time, and CNA #5 indicated Resident #49 was to be showered. CNA #5 was observed escorting Resident #49 for her shower at 7:40 A.M.

Resident #49 was observed seated at the dining room table on 5/16/11 at 11:45 A.M. A strong urine odor surrounded her. CNA #5 and LPN #2 assisted her to the bathroom. Her slacks had a large wet area on the backside indicating she had been incontinent of a large amount of urine.

LPN #2 indicated in an interview on 5/16/11 at 11:50 A.M., that many of the residents on the unit were incontinent and needed assistance with toileting. She further indicated there was a limited amount of staff on the unit and it made it difficult to provide the necessary care for residents requiring two person assist.

3. Resident #3's clinical record was reviewed on 5/19/11 at 2:00 P.M. and indicated diagnoses of, but not limited to: dementia, history of right femur fracture, depression, and constipation.

Resident #3 was observed sitting in her wheel chair across from the nurse's station at 4:10 P.M. on 5/16/11. She smelled of a strong urine odor. The odor was brought

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	155474	A. BUILDING 00 B. WING	05/24/2011

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	to the attention of CNA #30 who immediately took Resident #3 to her room. CNA #30 and LPN #25 were observed transferring Resident #3 to her bed via a mechanical lift at 4:20 P.M. (5/16/11). Resident #3's slacks were wet with urine but her incontinence brief was dry upon investigation. Further investigation of the source of odor indicated a large pool of urine underneath the pressure reducing cushion in her wheel chair. The top and bottom of the cushion were wet with urine. During interview with LPN #25, at the time of the observation, she indicated staff neglected to properly clean the wheel chair after providing her with previous incontinence care. 5. Resident # 20's record was reviewed on 5/18/11 at 4:45 p.m. The record indicated diagnoses of, but not limited to; Alzheimer's disease, hypertension, and depressive disorder. During a tour of the facility on 5/16/11 at 7:00 a.m. Resident # 20 was observed up and dressed. His face was observed to have several days of facial hair growth. Resident # 20's plan of care updated			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	5/10/11 indicated "Discharge not feasible related to; ...dementia, unable to care for self...Approach...provide care and services daily...." The Resident's record lacked a care plan specific for grooming needs. During an interview at that time with the ADON (Assistant Director of Nursing) she indicated the resident could do much for himself but needed cueing at times. She indicated the resident was very confused and was a wander risk. 6. Resident # 51's record was reviewed on 5/18/11 at 5:15 p.m. The resident's record indicated diagnoses of, but not limited to; diabetes, renal failure, peripheral vascular disease, hypertension, and depression. During a tour of the dining room on 5/16/11 at 8:30 a.m., an observation was made of Resident # 51 sitting at a dining table with other residents. Observation was made of her chin covered with a heavy growth of gray hairs. The Resident's quarterly MDS (minimum data set) assessment, dated 4/11/11, indicated the resident required extensive assistance with two staff assistance with personal hygiene. The resident's plan of care, dated 5/16/11, indicated " Problem; Requires physical			

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	155474	A. BUILDING 00 B. WING	05/24/2011

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assist of staff for ADL's (activities of daily living)...." The Resident's plan of care failed to indicate to keep her face free from chin hair.

7. Resident # 60's record was reviewed on 5/18/11 at 5:40 p.m. The Resident's record indicated diagnoses of, but not limited to; obstructive hydrocephalus; mental disorder, hypertension, impaired renal function, and obsessive compulsive disorder.

During a tour of the dining room on 5/16/11 at 8:30 a.m., an observation was made of Resident # 60 sitting at a dining table with other residents. Observation was made of the resident to have a large amount of facial hair. Long curly hairs above her lip and on her chin was observed.

The Resident's plan of care, updated 3/8/11, indicated "Problem: Alert and oriented with increased forgetfulness and confusion, needing reminders and prompts...." A care plan, dated 3/2/11, indicated "Problem; discharge not feasible...Approach indicated to provide care and services daily.

A form titled "Care Plan Conference Summary," dated 3/8/11, indicated "Plan of Care: Nursing: Supervision ADL's. The

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Resident's record lacked a plan of care addressing bathing and grooming needs. 8. Resident # 58's record was reviewed on 5/16/11 at 10:20 a.m. The resident's record indicated diagnoses of, but not limited to: dementia with behaviors, hip fracture, osteoporosis, kyphosis and seborrhea dermatitis. During a tour of the dining room on 5/16/11 at 8:30 a.m. an observation was made of Resident # 58 sitting at a table with other resident's. Resident # 58 was observed to have long curly facial hair on her upper lip and chin. Review of Resident # 58's quarterly MDS assessment, dated 5/2/11, indicated she needed limited assistance with one staff assistance for hygiene and bathing. The resident's plan of care dated 2/7/11, indicated "Requires physical assist with ADL's...Approach: Set up equipment for daily hygiene and provide cues for upper body tasks. Assist after she has tried...." The facility's policy and procedure titled "Quality of Life" dated 10/31/10 indicated "Policy: Care is provided in a manner and in an environment that maintains or enhances each patient's dignity and respect in full recognition of his or her			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	individuality...2. The patient is groomed as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped, removal of facial hair for women...." 4. The clinical record for Resident # 87 reviewed on 5/19/11 at 1:45 P.M., indicated diagnoses of, but not limited to, hepatitis C, spinal cord disease, paraplegia, and chronic pain. During interview with Resident # 87 on 5/16/11 at 2:45 P.M., two 50 gallon red biohazard barrels were present in the resident's room at the foot of the bed of the roommate. Resident # 87's Roommate was taken off isolation precautions on 5/13/11 and no longer had a need for the red barrels. The red barrels were observed in the room on 5/18/11 at 2:30 P.M. and 3:50 P.M., and on 5/19/11 at 3:40 P.M. Interview on 5/18/11 at 2:30 P.M., Resident # 87 indicated his roommate (Resident # 88) was already in the room when he was admitted on 2/24/11. He further indicated he asked the staff what the red barrels in the room were for. He indicated the staff told him they were for			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	some type of infection. RN # 20 on 5/19/11 at 4:10 P.M., indicated she the red barrels in Room (number) were for Resident # 87, but she was unsure what these were for. Interview with LPN # 9 on 5/20/11 at 9:45 A.M., she indicated the red barrels in Room (number) were originally for Resident # 88, but were now for Resident # 87. Observation of Room (number) on 5/20/11 at 9:45 A.M., the red barrels were no longer located in the room. Resident # 87 indicated the red barrels were just removed from the room. 9. On 5/18/2011 at 4:40 p.m., eleven residents (Resident #91, 59, 75, 70, 85, 54, 53, 68, 69, 55, 84) on the South Unit were observed sitting in the hall in wheelchairs against the wall facing the South Nursing Station and not engaged in any type of activity or conversation. An interview was conducted on 5/18/11 at 4:40 p.m. with LPN #3 indicating that the residents are lined up waiting for their dinner meal at 6:10 p.m. An interview was conducted on 5/18/11 at 5:04 p.m., with the Administrator indicating the residents are in front of the nursing station since they are a fall risk.			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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10. During a tour of the facility on 5/16/2011 at 4:00 p.m., an observation was made of 10 residents sitting in a small lounge adjacent to the nurse's station. Residents sitting in the North Lounge were Residents #7, #17, #21, #12, #8, # 3, # 32, #9, # 6, and # 18. The residents were in their wheelchairs and observed to be in close proximity of each other.

The television was observed to be playing in the room. The residents were not engaged in watching the television. Some of the residents were observed with their heads hanging down, sleeping in their wheelchairs.

Resident # 8 was observed yelling "Help. Help." over and over. She also was yelling, "Put me in my room, I'm cold."

Resident # 9 was heard yelling, "I got to go pee" over and over.

Resident # 18 was observed with his body leaning to the right in his wheelchair. His right arm was observed hanging over the side of the wheelchair.

LPN # 2 was observed to enter the lounge to calm down Resident # 8. She stated to the resident, "Supper is in a while."

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	During an interview with LPN # 2 at this time, she indicated supper time was at 6:00 p.m., and indicated the resident would wait in this room for two hours. She indicated she wouldn't know what else to do with them until then. 3.1-3(a)			
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview, observation, and record review, the facility failed to provide activities based on the needs of the individual residents. This deficient practice affected 1 of 9 resident reviewed for activities in a sample of 19. Resident: #27 Findings include: Resident #27's record was reviewed on 5-16-2011 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. An interview was conducted on 5/16/2011 at 12:41 p.m., with RN #10. RN #10	F0248	**F-248** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: Resident #27 has been reassessed related to functional level and his individualized plan of care has been updated to reflect enhanced participation in activity programming. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:All residents in the center were evaluated related to functional status and activity programming modified to enhance offerings for all functional levels. *The*	06/23/2011

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	indicated that Resident #27 only gets up twice a week for sensory group. RN #10 also verified that there is no order stating Resident #27 can only get up two times a week. On 5/17/11 at 9:15 a.m., Resident #27 was observed in the TV lounge during sensory group. No contact with Resident #27 was witnessed during this session. On 5/20/11 at 3:15 p.m., RN #8 verified Resident #27 was only transferred out of bed once from 5/16/11 through 5/20/11 for sensory group. The Comprehensive Care Plan Report with problem titled "Non-verbal-alert, but appears unaware of environment/surrounding," updated 4/5/2011, indicated, "...Place by TV lounge- place where he can be seen from Nurses Station through window...." The Comprehensive Care Plan Report with problem titled "d/t (due to) condition is dependent on staff for social and sensory stim (stimulation)" updated 4/5/2011 indicated, "...involve in small group at least 2x (twice) wkly (weekly)...When in lounge place where can be seen by nursing...observe for any changes and document...."		*measures put into place and a systemic change made to ensure the deficient practice does not recur is*:The Activity Director and activity staff along with nursing staff has been in-serviced related to enhance programming for all functional levels. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with resident involvement in activity programming at all functional levels. The Executive Director or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	The policy titled, "Activity Programs," dated 6/30/06, was reviewed on 5/24/11 at 2:15 p.m., stated, "...A resident's interests and needs are identified and a recreation (Activity) program designed to appeal to his or her interests and to enhance the resident's highest practicable level of physical, mental, and psychosocial well being...1. The recreation program occurs within the context of each resident's comprehensive assessment and care plan and reflects each individual resident's needs and preferences...b. Care plans address recreation programs that are appropriate for each resident based on the resident's skills, abilities, needs, and preferences...The recreation program: b. Provides stimulation or solace;...d. Care plan address issues, concerns, problems, or needs affecting the resident's involvement/engagement in activities...." 3.1-33(a)			
F0252 SS=E	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observations, interviews, and record review, the facility failed to ensure an environment free of urine odors for 2 (Residents #3 and #49) of 12 residents reviewed with incontinence in a sample of	F0252	**F-252** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The*	06/23/2011

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	19 and hallway clutter on the North and South Units which had the potential to affect all 79 residents residing on those units. Findings include: 1. During initial tour of the dementia unit on 5/16/11 at 7:00 A.M., while being accompanied by LPN #2, Resident #49 was identified as being incontinent. She was urine soaked, at the time, and CNA #5 indicated she was getting ready to give Resident #49 a shower. Resident #49's room smelled with a strong, pungent, urine odor. CNA #5 was observed escorting Resident #49 for her shower at 7:40 A.M. On 5/18/11 at 5:23 P.M., CNA #27 was observed providing incontinence care to Resident #49. Her room smelled from a strong urine odor and permeated out into the hallway.		*corrective action taken for the residents found to have been affected by the deficient practice was*:The rooms of resident #3 and #49 were thoroughly cleaned per daily room cleaning policy. All unnecessary care equipment and assistive devices have been removed from the hallways and will only be stored on one side of the hall when not in use. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:All resident rooms have been audited and cleaned as necessary per daily room cleaning policy. No other residents were found to have been affected by the deficient practice related to equipment storage. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Housekeeping staff has been in-serviced related to adherence to the deep clean schedule. All staff has been in-serviced related to unnecessary equipment storage in the hall. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with the daily room cleaning policy and proper equipment storage. The Executive Director or designee will complete indicator weekly for the first month, monthly for the	

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	155474	A. BUILDING 00 B. WING	05/24/2011

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			first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

2. During an observation on the following dates a strong urine odor was detected from Resident #3's room:
5/16/11 at 6:34 a.m.
5/16/11 at 10:10 a.m.
5/16/11 at 1:30 p.m.-Resident #3 not currently in room.
5/17/11 at 9:50 a.m.
5/17/11 at 2:50 p.m.- Resident #3 not currently in room.
5/18/11 at 12:40 p.m. - Resident #3 not currently in room.
5/19/11 at 10:00 a.m.

3. During a tour of the facility on 5/16/11 at 7:00 a.m., the halls on the north and south areas of the facility were observed to be cluttered with bedside tables, Hoyer lifts, trash barrels, housekeeping supplies, and walkers. The wheelchairs were lined up all along the side of the halls on both units, north and south. Medication carts were observed along the halls amongst the other items on both units. The hall floors were observed to be soiled with dirt debris.

During a group meeting on 5/17/11 at

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	10:30 a.m., with 10 alert and oriented residents, they all complained of the hallways in the facility being cluttered impeding their wheelchair mobility at times. On 5/18/11 at 6:45 a.m., the north hall near Room 122, the following was observed: housekeeping equipment in the hall, 2 large barrels containing trash and soiled linen, one of the lids was placed on one of the wheelchair cushions, 6 wheelchairs, 1 sweeper, 1 Hoyer lift and the medication cart was placed sideways impeding the travel of residents. Observation was made on 5/18/11 at 7:10 a.m., of a resident having trouble maneuvering his wheelchair down the hall when other residents pass by due to the hall clutter. 3.1-19(f)(5)			
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observations, interviews, and record review, the facility failed to ensure resident care equipment and resident common areas were clean and in good order related to the lounge and dining	F0253	**F-253** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the	06/23/2011

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	areas for 2 of 2 lifts used for residents who need assistance with mechanical transfers, for 2 of 2 residents (#27, #28) with padded siderails, and for 8 of 8 residents with wheelchairs (Resident's: #54, 14, #55, #18, #12, #70, #9, and #15) for 1 of 19 residents in a sample of 19 and 9 of 9 residents in a supplemental sample of 30. Findings include: 1. During a tour of the facility on 5/20/11 at 2:30 p.m., accompanied by Maintenance Director # 41 and the Housekeeping Director # 42, a standing lift on the south unit was observed to be ladened with dirt debris and food substance. A Hoyer lift observed on the north unit was observed to be laden with black dirt debris. During an interview at this time with the Housekeeping Director # 42 regarding the mechanical lift and the Hoyer lift, he indicated they are used for transferring some of the residents. 2. The north lounge carpet was observed to have a large wet area in front of the lounge door. The wet carpet was adjacent to the shower room. The Maintenance Director indicated the wetness probably leaked through from the shower room.		following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The side rails for residents #27 and #28 where thoroughly cleaned. The wheelchairs for residents #54, #14, #55, #18, #12, #70, #9, #15 were thoroughly cleaned. The mechanical lifts were cleaned. The carpet in the North Lounge has been extracted and free of wet spots. The unresolved tile work in the dining room has been completed. The cushion of resident #3's wheelchair was cleaned during the course of the survey. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No other residents were found to have been affected by the deficient practice. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: A cleaning schedule has been established for side rails, wheelchairs, wheelchair cushions and mechanical lifts to ensure ongoing cleanliness. Carpeted areas are on a routine cleaning schedule and will be monitored on a daily basis by housekeeping supervisor or facility manager for immediate resolution. All staff has been in-serviced on the importance of incontinence care, elimination of odors, and clean wheel chairs and wheel chair	

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	Upon inspection of the shower room, he indicated there was no way it came from the shower room and was unsure how the carpet became wet. 3. The walls in the north dining room where residents eat their meals was observed to have ceramic tiles 4 foot up from the floor. The tiles failed to have grout in the spaces. Several of the tiles had plastic spacers in the grooves. The walls near the kitchen entrance was observed to be bare with orange colored glue on the wall board. During an interview with the Administrator on 5/20/11 at 4:50 p.m., regarding the unfinished wall tiles, he indicated the project was started a year ago and hasn't been completed. 4. The following observations were made of soiled wheel chairs in the main dining room on 5/16/11 at 6:00 P.M.: Resident # 54's wheel chair had a dried white substance on the metal frame and leg rest. 5. Resident #14's front wheels, frame, and brake of his wheel chair were soiled with dried food. 6. Resident #55's wheel chair was soiled		cushions. The facility implemented a wheelchair/cushion-cleaning schedule and a facility walk through to see if there were any other issues causing odors. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with elimination of odors and maintaining clean equipment. The Executive Director or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution.POC Date: 6/23/11	

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	with a dark brown dried substance on the right arm rest, frame, and front wheels. 7. Resident #18's front right wheel of his wheel chair was soiled with a dried brown dripping. 8. Resident #12's front wheels and frame of the wheel chair were soiled with a dried white substance. 9. Resident #70's right large wheel of her wheel chair was soiled with a dried brown and tan substance. 10. Resident #9's large wheel and spokes were soiled with a large amount of a white dried substance. 11. Resident #15's foot pads and pedals were covered with a dried white and beige crusty dried substance. An orange/red dried substance was on the right side framework. The right and left brake had gray dust particles and the seat of his wheel chair had dried spillage. 12. CNA #30 and LPN #25 were observed transferring Resident #3 to her bed via a mechanical lift at 4:20 P.M. (5/16/11). Resident #3's slacks were wet with urine but her incontinence brief was dry upon investigation. Further investigation of the source of odor			

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	indicated a large pool of urine underneath the pressure reducing cushion in her wheel chair. The top and bottom of the cushion were wet with urine. 13. During an observation on 5/16/2011 at 6:34 a.m., Resident #27's was noted to have several pencil eraser sized white and yellow, dried substances on the padded side rail. 14. During an observation on 5/16/2011 at 6:34 a.m., Resident #28's was noted to have several pencil eraser sized white and yellow, dried substances on the padded side rail. An interview was conducted in the Nurses Station on 5/16/11 at 11:02 a.m., with RN #10. RN #10 stated that the white and yellow substances on the padded side rails has been there and should probably be cleaned off by one of the CNAs. 3.1-19(f)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview, and record review, the facility failed to: perform an assessment following a respiratory decline and assess for pain control. This deficient practice affected 2 of 19 residents reviewed for comprehensive assessments in a sample of 19. (Res# 27, 40)	F0272	**F-272** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:A current respiratory assessment was completed for	06/23/2011

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	Findings include: 1. Resident #27's record was reviewed on 5-16-2011 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. On 5/16/2011 at 6: a.m., Resident #27 was observed during tour with a tracheotomy and oxygen at 4 liters via a tracheotomy mask. On 5/16/2011 at 6:11 p.m., RN # 6, RN #7, RN #8 and the ADON (Assistant Director of Nursing) were observed providing care to Resident # 27. Once care was completed, all the staff except the ADON left the room. At 6:30 p.m., when surveyors were exiting the room a large amount of mucus was noted inside of the outer cannula of the tracheotomy. The ADON was asked to lift the sheet to allow observation of the nail beds. Resident #27's nail beds were blue/gray in color and the fingers were mostly blue in color. Resident #27 was also noted to be experiencing a violent cough. The inner lumen of the oxygen tubing was noted to be completely obstructed with mucus. At 6:42 p.m., RN #8 was requested to return to the room with a biox (to test blood oxygen levels), Resident # 27's biox		resident #27. Despite omission in the MAR, the nurse documented administration of resident #40's pain medication in the nurse's progress notes. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: A full facility audit was conducted and all pain assessments updated. In addition, all residents were reviewed for additional needed respiratory assessment. No other residents were found to be in need of additional respiratory assessment. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Licensed nursing staff has been in-serviced related to respiratory and pain assessment. In addition licensed nurses have completed return demonstration and competency testing related to suctioning and tracheostomy care. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with respiratory and pain assessment. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	was 84%. At 6:49 p.m., RN #8 brought suction equipment to room. Resident #27 observed coughing and gagging. At 6:54 p.m., Resident #27's biox is 87%, oral mucus secretions visualized, Resident #27 was observed gagging. At 6:57 p.m., the biox was 86%, mucus was observed gurgling from resident's mouth. At 7:11 p.m., Resident #27's room and was coughing violently, gagging, and flailing forward in bed. Biox was 89%. At 7:18 p.m., a different biox was brought to the room, Resident #27's biox was then 93%. On 5/17/11 at 7 p.m., RN #8 verified that Resident #27 experienced a decline in respiratory function on 5/16/11 from 6:11 p.m. until 7:18 p.m. RN #8 indicated a respiratory assessment was not completed prior to suctioning or immediately after this incident by staff to determine lung function/sounds. The policy titled, "Comprehensive Assessment" dated 3/05/08 was reviewed on 5/24/11 at 2:30 p.m. stated, "...Definition- Assessment Data- Resident data collected so that an analysis/evaluation of the resident's physical and mental condition or abilities may be determined by the appropriate			

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	discipline. Data is documented on assessment forms. Data may include, but is not limited to: Vital signs...Resident changes...Observation of symptoms...Pulse oximetry...Response to treatment...Effectiveness of treatment ...Oral status...." The policy titled, "Endotracheal Care & Suctioning," dated 10/31/07, was reviewed on 5/24/11 at 2:45 p.m., stated, "Rationale- Suctioning of the resident's airway removes increased secretions and prevents airway obstruction and aspiration...Indications for Suctioning- More frequent or congested-sounding cough...visible secretions...Decreased vital capacity and/or oxygen saturation (as indicated by pulse oximetry), thought to be related to mucus plugging...Hazards and Complications- Trauma to the oral, tracheal, or bronchial mucosa; Cardiac arrest; Respiratory arrest...bronchospasm or bronchoconstriction; Airway infection...Procedure-...Assessment of outcome...Documentation of Guidelines-...2...a. Respiratory status...3...a. Date and time of physician notification...4. Notification of family member/responsible party...." 2. Resident #40's clinical record was reviewed on 5/16/11 at 2:35 P.M. and indicated diagnoses of, but not limited to: history of sacral/pelvic fracture,			

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	osteoporosis, macular degeneration, senile dementia, and osteoarthritis of the hips. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, she indicated Resident #40 had sustained an irreparable fractured right hip from a recent fall on the unit. Resident #40 had facial grimacing and indicated she was having pain at the time. Resident #40 was observed on 5/16/11 at 12:25 P.M., screaming out in pain when she was pulled up in her bed by LPN #2 and CNA #5. Review of Resident #40's Medication Administration Record (MAR) on 5/16/11 at 12:30 P.M., indicated she had been medicated with Norco (narcotic pain medication) 5 mg. (milligram) at 6:00 A.M. She received 650 mg. of acetaminophen (over-the-counter analgesic) and 100 mg. of Tramadol (non-narcotic pain medication) at 8:00 A.M. During interview with LPN #2, at the time of the above observation, she stated, "We need to get some of the PRN (Norco) in her." Further review of the MAR indicated LPN #2 medicated Resident #40 with the PRN (as needed) Norco 5 mg. at 12:30 P.M., for her breakthrough pain.			

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	A Physician's Order, dated 5/4/11 at 1:20 P.M., indicated, "Norco 5/325 (Hydrocodone 5mg [milligram]-325 mg APAP [acetaminophen]) tablets. Give i (one) PO (by mouth) TID (three times/day) 6 A.M., 2 P.M., 10 P.M. Keep PRN (as needed) Norco order for breakthrough pain...." Resident #40's MAR indicated she received the PRN (as needed) Norco for breakthrough pain on the following dates and times: 2 times (x's) on 5/04/11: 12:30 and 8:30 P.M. (no routine Norco given on 5/04/11); 1 x on 5/05/11: 6:00 P.M.; 3 x's on 5/06/11: 2:00 A.M., 10:00 A.M., and 6:00 P.M.; 1 x on 5/07/11: 10:15 A.M.; 3 x's on 5/08/11: 2:00 A.M., 10:00 A.M., and 6:00 P.M.; 1 x on 5/09/11: 2:00 A.M.; 1 x on 5/11/11: 6:00 P.M.; 1 x on 5/13/11: 6:00 P.M.; 1 x on 5/14/11: 6:00 P.M.; 2 x's on 5/16/11: 12:30 P.M. and 4:00 P.M.; 1 x on 5/17/11 at 2:00 A.M. Resident #40 received a total of 17 doses of the PRN Norco (for breakthrough pain) over the 15 day period of 5/04/11 through 5/18/11. On 5/16/11 at 4:50 P.M., Resident #40 indicated in an interview she was having "bad" pain in her right hip and was fearful of being moved in bed. Review of her MAR, at the time, indicated she had not been given her 2:00 P.M. scheduled dose of Norco, but had received another dose			

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	of the 650 mg. acetaminophen and 100 mg. of the Tramadol at 2:00 P.M. She received a PRN dose of Norco at 4:00 P.M. During interview with Resident #40 on 5/17/11 at 9:10 A.M., she indicated she was having pain in her right hip, but was unable to rate her pain on the 0-10 pain scale. The MAR indicated a Norco 5 mg. had last been given to Resident #40 at 6:00 A.M. Nurse's Notes indicated, "5/17/11 at 3:45 P.M.-...Yells out when moved...5/17/11 at 9:45 P.M.-Resident has lots of pain with any movement...5/18/11 at 10:00 A.M. -...Res. c/o pain R hip. Pain when pulled up in bed with 2 assist...." The Director of Nursing (D.O.N.) indicated in an interview on 5/18/11 at 11:15 A.M., a Physician's Order had been obtained for Morphine Sulfate (a strong, fast-acting pain narcotic) 5 mg. to be administered every two hours for breakthrough pain. "The Vicodin (Norco) wasn't controlling her pain. We were using the PRN Vicodin, but it wasn't doing the job." A Physician Order, dated 5/18/11, indicated, "Morphine Sulfate Suspension 20mg/ml (milliliter) give 5 mg. PO or			

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	sublingual Q 2 hrs (hours) for breakthrough pain." CNA #12 and CNA #14 were observed providing incontinence care to Resident #40 on 5/19/11 at 1:10 P.M. Resident #40 moaned when the head of her bed was lowered to a flat position and screamed out in pain when her legs were touched. Resident #40 was rolled onto her right hip so she could be washed. She screamed out in pain as she was rolled. CNA #14 then reached across the bed and pulled on Resident #40's right thigh while CNA #12 pushed on her right hip to turn her over onto the left hip. Resident #40 screamed out in pain and yelled "My leg. My leg. No. No." Review of the MAR indicated Resident #40 had not received her Morphine Sulfate since 4:00 A.M. on 5/19/11. Resident #40's Care Plan, dated 5/10/11, indicated, "Problem: Fracture: Right Hip Resident Fall. Goal: Resident will have no complications and minimal pain from hip fracture. Approach: ...Administer pain medication as ordered and check for effectiveness...." A facility policy titled "Pain Management," revised 4/28/09, indicated, "Policy: The center's practice is to assist			

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	each resident with pain or that has a potential for pain to maintain or achieve the highest practicable level of well being and functioning through pain management...6. The center provides orientation and ongoing staff education to correct misconceptions, myths, and biases about pain. Training my (sic) include, but is not limited to: ...b. recognizing and assessing pain...and monitoring interventions...." 3.1-31(a)			

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F0278 SS=A	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure the MDS (Minimum Data Set) was accurate for 1 of 19 residents reviewed for MDS's in a sample of 19. Resident # 87 Findings include: 1. The clinical record for Resident # 87 reviewed on 5/19/11 at 1:45 P.M.,	F0278	**F-278** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The diagnosis of Hepatitis C was added to the MDS for resident number #87 on 5/23/11 and transmitted. *The corrective action taken for those residents*	06/23/2011

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	indicated diagnoses of, but not limited to, hepatitis C, spinal cord disease, paraplegia, and chronic pain. Review of the "Resident Care System, Diagnosis Sort Order", printed 3/30/11, indicated, "...HPT (hepatitis) C...effective date...2/24/11...admit date 2/24/11... The MDS (Minimum Data Set), dated 4/20/11, Section I - Active Diagnoses lacked documentation of Hepatitis C. During daily conference on 5/23/11 at 6:30 P.M., the DON (Director of Nursing) was informed of the lack of Resident # 87's diagnosis of Hepatitis C being documented on the MDS. She further indicated she would talk with the MDS coordinator. 3.1-31(d) 3.1-31(i)		*having the potential to be affected by the same deficient practice is*: The medical records for all other residents were audited to ensure active diagnoses are indicated appropriately on the MDS for the last two physician visits. Any other MDS's required to be submitted to the state will be submitted as needed. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The MDS coordinators will ensure active diagnoses are reflected on current physician orders as evidenced by resident's history and physical and dictated progress notes. The MDS staff has been in-serviced related to ensuring all active diagnoses are indicated on the MDS. *To ensure the deficient practice does not recur, the monitoring system established is*:A performance improvement indicator has been established that evaluates the compliance of active diagnoses appropriately reflected on the MDS. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview, and record review, the facility failed to create a comprehensive care plan to address all pressure ulcers, Hepatitis C, mechanical lifts, and side rail pads to ensure the resident's highest level of physical, mental, and psychosocial well being is attained while residing in this facility. This deficient practice affected 4 of 19 residents reviewed for comprehensive care plans in a sample of 19. (Res# 92, 87, 10, 11) Findings include: 1. Resident #92 record was reviewed on 5-19-2011 at 1:55 p.m. Resident #92's	F0279	**F-279** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The care plans for residents #92, #87, #10 and #11 have been reviewed and amended to include the following: #92 – a preventative care plan for pressure ulcers#87 – a care plan related to the diagnosis of Hepatitis C#10 – use of padded rails#11 – appropriate equipment for transfers *The corrective action taken for those residents having the potential to be affected by the*	06/23/2011

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	diagnoses include, but were not limited to, dementia, peripheral neuropathy, edema, and hemiplegia. The "Resident Progress Notes," dated 1/4/11 at 8:20 a.m., stated, "Res (resident) was found c (with) 2 new bruises this am (morning), on back of heels bilaterally. R (right) bruise measures 1.2 c.m. x 0.5 c.m., L (left) bruise measures 1 c.m. x 0.4 c.m. MD notified." The Physician Orders, dated 1/5/11 at 10:50 a.m., stated, "...Proderm to bilateral heels TID (three times daily) until healed...." During a review of the "Weekly Pressure Ulcer Condition Report," indicated that the bilateral heel wounds were healed on 5/18/11. This report also stated, "...Date of first observation: 1/4/11...." for bilateral heel wounds. An interview was conducted on 5/19/11 at 4:45 p.m., with LPN #3. LPN #3 was unable to find a care plan addressing prevention or care of heel pressure ulcers. LPN #3 indicated that the documentation should be on the chart. The policy titled, "Pressure Ulcer Prevention," dated 4/28/09, was reviewed on 5/24/11 at 3:40 p.m., and stated,		*same deficient practice is*: The care plans for all residents were reviewed to ensure they accurately reflect the resident's current status. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The care plans of each resident will be updated during the Monday through Friday clinical meeting with receipt of any new orders, diagnosis or assistive care device. *To ensure the deficient practice does not recur, the monitoring system established is*:A performance improvement indicator has been established that evaluates the compliance with the presence of care plans accurately reflect the care needs of the residents. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	"Policy- A resident who enters the center without pressure ulcers and/or other non-pressure ulcers does not develop pressure ulcers and/or other non-pressure ulcers, unless the individual's clinical condition demonstrates that they were unavoidable. The center provides care and services to: a. Promote the prevention of pressure ulcer development b. Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and c. Prevent development of additional pressure ulcers...15. Develop care plan on the degree and areas of risk and update as necessary...." 2. The clinical record for Resident # 87 reviewed on 5/19/11 at 1:45 P.M., indicated diagnoses of, but not limited to, hepatitis C, spinal cord disease, paraplegia, and chronic pain. A "History and Physical," dated 2/26/11, performed by (Name) M.D., indicated, "Hepatitis C...right now he will be on universal precautions..." The clinical record lacked documentation of a developed care plan regarding the diagnosis of Hepatitis C. CNA # 22 on 5/19/11 at 3:55 P.M., indicated she was unaware of the Resident's diagnosis of Hepatitis C.			

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	During daily conference on 5/23/11 at 6:30 P.M., the DON (Director of Nursing) was informed of the lack of a care plan related to Resident # 87's diagnosis of Hepatitis C. No further information was presented to the survey team prior to final exit on 5/24/11. A facility policy titled "...Hepatitis C...", revised 10/31/06, indicated, "...Universal Precautions, Standard Precautions apply..." 3. Resident # 10's record was reviewed on 5/16/11 at 10:00 a.m. The Resident's record indicated diagnoses of, but not limited to; stroke, gastric feeding tube, diabetes, aphasia, dysphasia, seizure disorder and hypertension. During a tour of the facility on 5/16/11 at 7:00 a.m., an observation was made of Resident # 10's side rails padded with dark blue pads. Resident # 10's care plan, updated on 4/19/11, indicated, "Problem: Seizure disorder 1/2 side rails up X (times) 2 as seizure precautions...Approach: 1/2 side rails up X (times) 2 as seizure precautions...." The care plan had the word padded crossed out.			

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	During an interview with LPN # 9, on 5/16/11 at 7:10 a.m., she indicated to her knowledge, the side rails are always kept padded. She indicated the care plan should have been developed to always use the padded rails. 4. Resident # 11's record was reviewed on 5/17/11 at 3:20 p.m. The Resident's record indicated diagnoses of, but not limited to; paralysis of the lower limbs, pressure ulcers, depression, and diabetes. During an interview with alert and oriented Resident # 11 on 5/18/11 at 2:10 p.m., he indicated he gets up occasionally and the staff use a Hoyer lift to transfer him. He further indicated he is not able to be up long due to his pressure ulcers. A physician's order, dated 4/12/11, indicated "Mech (mechanical) lift for all transfers...." The Resident's plan of care reviewed on 5/17/11 at 3:40 p.m., dated 4/19/11 failed to indicate how the resident was transferred. The plan of care did not indicate a Hoyer lift was used or how many staff would be used to transfer the Resident. A nurses note, dated 5/6/11 at 9:30 a.m., indicated "...turned and rep (repositioned)			

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	routinely, mech (mechanical) lift and 2 assist for all transfers...." 3.1-35(a)			
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview and record review, the facility failed to ensure a care plan had been updated for 1 of 1 resident reviewed with a significant weight loss in a sample of 19. (Resident # 54) Findings include: Resident #54's record was reviewed on 5/18/11 at 8:50 a.m. The resident's record indicated diagnoses of, but not limited to; right cerebral vascular accident, dementia,	F0280	**F-280** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The care plan for resident #54 has been reviewed and amended related to significant weight loss. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: All	06/23/2011

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	osteoporosis and cardiomegally. On 5/17/11 at 1:00 p.m., Resident # 54 was observed in the dining room. The resident was observed refusing to eat her lunch. Staff attempted to assist the resident with her meal, she refused to eat. The Resident's weights for the month of January 9th, 2011 was 141 pounds. February 9th, 2011's weight was 155.2. March 6th, 2011 weight was 156.7 pounds. April 2011 weight was 155.5, and May 2011 weight was 128.5. The resident's reweight for May was recorded at 126.9 pounds. The weight loss calculated at 28.6 pounds lost from April to May, 2011. The resident's plan of care, dated 3/15/10, indicated "Problem: Significant weight loss (March 2010) Leaves 25% or more uneaten most meals, at risk for choking Dx (diagnosis) Hiatal Hernia, Dx: Dysphagia...Approach:...Notify RD and MD of significant weight changes...." The resident's plan of care was last updated on 4/5/11. No further documentation was observed on the plan of care to address the 28.6 pound weight loss the resident experienced. The plan of care failed to indicate the resident refuses to eat her meals at times.		residents will be reviewed to identify any other significant weight loss. Appropriate care plans and interventions will be initiated as necessary. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The Registered dietician has been in-serviced on timely updating of care plans and associated interventions. *To ensure the deficient practice does not recur, the monitoring system established is*:A performance improvement tool has been developed which evaluates the presence, timeliness and appropriateness of care plans for those residents who have experienced a significant weight loss. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	During an interview with the Director of Nursing regarding the plan of care on 5/20/11 at 5:10 p.m., she indicated the care plan should have been updated when the weight loss was noticed. The facility's policy titled "Nutritional Risk, Nutritional Problem and/or Significant Change," dated 10/31/10, indicated "...Significant Change, a decline or improvement in a patient's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard diseased-related clinical interventions, is not "self-limiting", b. Impacts more than one area of the patient's health status; and c. Requires interdisciplinary review of the care plan ...10. Update care plan to include the status change, if applicable...." 3.1-35(a)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interviews and record reviews, the facility failed to ensure a resident with a gastric feeding tube and receiving nutrition through a pump was cared for by a licensed staff person for 1 of 2 residents reviewed with	F0281	**F-281** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the*	06/23/2011

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	gastric feedings in a sample of 19 (Resident # 10), and also failed to have nursing staff with sufficient knowledge of tracheotomy suctioning for 1 of 1 residents with a tracheotomy needing to be suctioned in a sample of 19 (Resident # 27). Findings include: 1. Resident # 10's record was reviewed on 5/16/11 at 10:00 a.m. The Resident's record indicated diagnoses of, but not limited to; stroke, gastric tube, diabetes, dysphagia and aphasia. The Resident's record indicated she receives gastric feedings by way of a pump at 45 cc (cubic centimeter) and hour continuously. During a tour of the resident's room on 5/16/10 at 3:40 p.m., an observation was made of CNA # 24 transferring Resident # 10 into her recliner via a Hoyer lift. The resident was observed to be unhooked from her feeding pump during the transfer. Once the resident was placed in her chair, CNA # 24 was observed to hook up the pump feeding to Resident # 10's gastric tube and turn the pump on to 45 cc/hour. During an interview with LPN # 25 on		*residents found to have been affected by the deficient practice was*:CNA #24 was educated related to scope of practice to include not hooking or unhooking the g-tube feeding for any resident. Licensed nurse verified placement and checked residual of resident #10's g-tube following the incident. RN #8 was immediately re-educated on sterile technique and completing tracheostomy suctioning per facility policy. The physician for resident #27 has completed an assessment and completed an updated physician progress note relative to the resident's condition. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No other residents have been observed to be affected by these practices. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Certified nursing assistants have been in-serviced related to scope of practice to include G-Tube care. All licensed nursing staff has been in-serviced and completed competency testing and return demonstration related to tracheostomy care and suctioning. The Staff Development Coordinator has and will continue to observe the staff suctioning during trach care. *To ensure the deficient practice does not recur, the monitoring*	

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	5/16/11 at 3:40 p.m., regarding a CNA hooking up the resident's tube feeding and turning on the pump, LPN # 25 stated "No, CNA's are not supposed to unhook or hook up a G-tube (gastric tube.) LPN # 25 also indicated a nurse would need to check for placement and the residual prior to starting a feeding. According to Lippincott's Manual of Nursing Practice 4th Edition regarding gastric feeding tubes "Continuous Nursing Assessment, 1. Recognize that even though some nutritional deficits are corrected, other problems may arise, such as fluid deficit...esophageal reflux...3. Aspirate the tubing prior to feeding to verify that the tube is in place. 4. Avoid air bubbles in the system which could cause distention...." 2. Resident #27's record was reviewed on 5-16-2011 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. On 5/16/11 at 6:52 p.m., RN #8 was observed completing tracheotomy suctioning on Resident #27. RN #8 broke sterile technique while putting sterile gloves on twice by touching the sterile area with his bare hands. RN #8 also		*system established is*:A Performance Improvement indicator has been established which evaluates compliance with observing certified nursing assistants in provision of care to ensure no violation of scope of practice and direct care observations of licensed staff across all three shifts on the proper technique related to suctioning and tracheostomy care. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	failed to dip the suction catheter into sterile water before use to check for functioning equipment and lubricate the suction catheter before beginning the procedure. RN #8 then suctioned while inserting the catheter into the tracheotomy. Suctioning was longer than ten seconds and not intermittent. RN #8 did not wait for thirty seconds between suctioning episodes. There was no respiratory assessment completed during or immediately after this incident. According to Lippincott's Manual of Nursing Practice 4th edition for suctioning a resident with a tracheostomy, "The patient with an ineffective cough cannot clear his secretions and requires mechanical aspiration (suctioning). It is a sterile procedure. Secretion collection in the artificial airway or tracheobronchial tree may result in narrowing of the airway, respiratory insufficiency, increased work of breathing and stasis of secretions. The policy titled, "Endotracheal Care & Suctioning," dated 10/31/07, was reviewed on 5/24/11 at 4:15 p.m. stated, "...Rationale: Suctioning of the resident's airway removes increased secretions and prevents airway obstruction and aspiration...Procedure...4. wash hands. 5. Open suction catheter package. 6. Put on goggles and sterile gloves and remove			

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	suction catheter. 7. With the un-sterile hand, disconnect the resident from the aerosol or oxygen. 8. Gently pass the suction catheter down the endotracheal tube until resistance is met then withdraw the catheter slightly. 9. Apply suction while removing the catheter. 10. Re-oxygenate the resident...11. Repeat steps 8-10 until all secretions have been removed or up to the resident's tolerance of the procedure...Assessment of Outcome...12. Determine if suctioning has been successful by one or more of the following: a. Removal of secretions; b. Improvement of breath sounds...e. clearing of cough...13. When completed, place resident back on the aerosol or oxygen...Documentation of Guidelines-...2...a. Respiratory status...3...a. Date and time of physician notification...4. Notification of family member/responsible party...." 3.1-35(g)(1)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interviews, observations and record reviews, the facility failed to	F0282	**F-282** It is the practice of this facility to	06/23/2011

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	ensure residents receiving gastric feedings by way of a pump was properly positioned in bed for 2 of 2 resident reviewed with gastric feedings (Residents: #10 and #27) and 1 of 1 resident needing his heels properly positioned (Resident # 80) and for failing to ensure 1 resident with thickened liquids had the proper consistency of fluid at her bedside for 1 of 1 resident reviewed with thickened fluids (Resident # 54) and for failing to ensure 3 residents received the correct dose of insulin for 3 of 5 residents reviewed with insulin orders in a sample of 19 (Residents: # 11, # 3 and # 80) Findings include: 1. Resident # 10's record was reviewed on 5/16/11 at 10:00 a.m. The Resident's record indicated diagnoses of, but not limited to; stroke, gastric tube, diabetes, dysphasia and aphasia. The resident's record indicated she receives gastric feedings by way of a pump at 45 cc (cubic centimeter) and hour continuously. The resident's record indicated "Aspiration alert" on the physicians order sheet. During a tour of the facility on 5/16/11 at 6:35 a.m., Resident # 10 was observed in her bed with her body flat. The resident's		ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: Residents #10 and #27 were immediately repositioned as per facility policy for residents receiving gastric feedings. The water pitcher was removed from the bedside table of resident #54 during the course of the survey. The heels of resident #80 were repositioned to ensure flotation of heels. The physician for residents #3, #11 and #80 were notified of the errors related to sliding scale dosage or missed doses of insulin. Resident #3 does not have physician orders for glucometer testing at 12pm. and 6pm. This resident does receive sliding scale insulin coverage for glucometer testing at 6am and 4pm. Per review of resident #3's MAR, the correct amount on insulin was administered for glucometer results on 3/21/11, 3/24/11, and 3/25/11. In addition, the physician for resident #3 was notified of the medication error related to Diltiazem and 02 sats with no new orders received. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:A facility wide audit was conducted to identify those requiring elevated head of bed,	

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	bed was raised, but the resident had slid down in the bed placing her body in a flat position. The resident's feeding pump was observed hooked up to the resident with the pump observed running at 45 cc's (cubic centimeters) an hour. During an interview with the ADON at that time, she indicated the resident should have been placed higher in the bed. A physician's order, dated 6/10/05 to current, indicated "HOB (head of bed) up 30 degrees at all times." 2. During a tour of the facility on 5/16/11 at 7:00 a.m., an observation was made of Resident # 54 having a pitcher of thin water sitting on her bedside table. A plastic cup was sitting next to the pitcher of water. During an interview with the ADON at this time, she indicated the resident should not have water at her bedside because she is on nectar thickened fluids only. Resident #54's record was reviewed on 5/18/11 at 8:50 a.m. The resident's record indicated diagnoses of, but not limited to; right cerebral vascular accident, dementia, osteoporosis and cardiomegally.		thickened liquids, sliding scale insulin and pressure relieving devices to ensure all necessary interventions are in place according to the resident's plan of care. A facility wide medication administration record and treatment administration record audit for the month of June has been conducted to review compliance with all medications requiring specialized parameters. Any variances to prescribed treatment regime will be reported to the physician for further review and recommendation. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Nursing staff has been in-serviced related to appropriate positioning to include elevation of the head of bed, compliance with provision of thickened liquids, administration of sliding scale insulin, application of pressure relieving devices and following physician orders. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with following physician's orders to include elevation of the head of bed, compliance with provision of thickened liquids, administration of sliding scale insulin, application of pressure relieving devices. The Director of Nursing or designee will complete indicator	

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	A physician's order, dated 1/27/10, reviewed at this time indicated "Pureed diet with Nectar Thick Liquids." The physician's order sheet also indicated "Aspiration Alert." 3. Resident # 11's record was reviewed on 5/17/11 at 3:20 p.m. The Resident's record indicated diagnoses of, but not limited to; paralysis of the lower limbs, pressure ulcers, depression, and diabetes. A physician's order, dated 4/8/11, indicated "Novolog Sliding Scale before meals. Novolog 100u/ ml (milliliter), < 0-100 = 20 units...." The Resident's MAR (medication administration record) indicated on 5/12/11 at 6:00 a.m. the resident's blood glucose level was 95. The sliding scale ordered by the physician, indicated the resident was to receive 20 units of the Novolog insulin. The MAR indicated the resident received 25 units instead of the ordered 20. During an interview with LPN # 3 on 5/17/11 at 3:30 p.m., regarding the error on the resident's MAR, she reviewed the MAR and indicated the wrong dose was given. 4. Resident #3's record was reviewed on		weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	5-19-2011 at 2:00 p.m. Resident #3's diagnoses include, but were not limited to, Diabetes Mellitus, dementia, history of a right femur fracture, and depression. The "Physician Order's" dated 1/28/2011 stated, "...Sliding scale, if blood sugar 0-150= 0 units, 151-200= 3 units, 201-250= 6 units, 251-300= 9 units, 301-350= 12 units, 351-400= 14 units, call MD if blood sugar less than 60 or greater than 400...." The "Medication Record" on 5/1/11 at 4:00 p.m., Resident #3's blood sugar was 200 and 9 units were given. The "Medication Record" on 5/12/11 at 6:00 a.m., Resident #3's blood sugar was 171 and no insulin coverage was documented. The "Medication Record" on 5/13/11 at 6:00 a.m., Resident #3's blood sugar was 227 and no insulin coverage was documented. The "Medication Record" on 5/13/11 at 4:00 p.m., Resident #3's blood sugar was 152 and 2 units were given. The "Medication Record" on 3/21/11 at 6:00 p.m., Resident #3's blood sugar was not taken and no coverage was given.			

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The "Medication Record" on 3/24/11 at 6:00 p.m., Resident #3's blood sugar was not taken and no coverage was given.

The "Medication Record" on 3/25/11 at 12:00 p.m., Resident #3's blood sugar was not taken and no coverage was given.

The "Medication Record" for the month of April 2011 stated, "...Diltiazem (a medication used to treat an irregular heart rhythm) 60 mg. Give 1 tablet by mouth every 6 hours. Dx (diagnosis): AFIB (atrial fibrillation) *Hold if SBP (systolic blood pressure) <90 [less than 90]...."

The "Physician Orders" dated 4/1/11 through 4/30/11 stated, "...Diltiazem 60 mg. Give 1 tablet by mouth every 6 hours. Dx: AFIB *Hold if SBP (systolic blood pressure) <90

The "Medication Record" lacked documentation that Resident #3's blood pressure was taken twice during the month of April and no medication was administered.

The "Medication Record" for the month of May 2011 stated, "...Oxygen per nasal cannula to keep oxygen saturation above 90% may wean as tolerated...."

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	The "Physician's Orders" dated 5/1/11 through 5/31/11 stated, "...Oxygen per nasal cannula to keep oxygen saturation above 90%. May wean as tolerated...." The "Medication Record" lacked documentation that a biox (blood oxygen level) was taken 4 times during the month of May 2011. 5. Resident #27's record was reviewed on 5/16/11 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. On 5/16/11 at 6:34 a.m., Resident #27 was observed with the head of the bed below 30 degrees while tube feeding was running at 65 cc an hour. An interview was conducted with the ADON (Assistant Director of Nursing) on 5/16/11 at 6:34 a.m. The head of the bed was verified below 30 degrees. Also indicated that the head of the bed should be between 30 and 45 degrees. 6. The clinical record for Resident # 80 reviewed on 5/16/11 at 10:45 A.M., indicated diagnoses of, but not limited to, diabetes mellitus, acute kidney failure, peripheral neuropathy, and bilateral heel pressure ulcers.			

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a. Resident # 80's Care Plan, dated 3/4/11 and 3/7/11, updated 4/19/11, indicated, "...Keep heels a float...Heez (sic) up cushion to bed..."

During observation of the wounds on 5/20/11 at 1:50 P.M., with LPN # 9, Resident # 80 was resting in bed with the Heelz up cushion under her thighs and her heels on the bed. LPN # 9 indicated the Residents heels are to be up off the bed but the cushion slides around and doesn't stay in place.

b. A Physician Order, dated 2/5/11, indicated, "...Glucometers twice daily...Sliding Scale. If blood sugar 60-150=0 units, 151-200=4 units, 201-250=8 units, 251-300=12 units, 301-350=14 units, 351-400=16 units, Call MD if blood sugar less than 60 or greater than 350...."

Review of the February 2011, MAR (Medication Administration Record) indicated Residents # 80's blood sugars as follows:

2/12/11 at 4:00 P.M. - 296. The clinical record lacked documentation of coverage.
2/27/11 at 6:00 A.M. - 208. The clinical record indicated 4 units given.

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	Review of the March 2011, MAR indicated blood sugars as follows: 3/1/11 at 6:00 A.M. - 201. The clinical record indicated 4 units given. 3/16/11 at 4:00 P.M. - 274. The clinical record indicated no coverage given. 3/24/11 at 4:00 P.M. - 338. The clinical record indicated 16 units given. Review of the April 2011, MAR indicated blood sugars as follows: 4/9/11 at 4:00 P.M. - unable to read result. The clinical record indicated 12 units given. 4/12/11 at 4:00 P.M. - 243. The clinical record lacked documentation of coverage. Review of the May 2011, MAR indicated blood sugars as follows: 5/17/11 at 6:00 A.M. - 178. The clinical record lacked documentation of coverage. Review of the February 2011, March 2011, April 2011, and May 1 through 17, 2011, MAR indicated, Resident # 80 received incorrect sliding scale coverage on eight occasions. Resident # 80's Care Plan, dated 5/19/11, indicated, "...Medication as ordered. See Physician's Orders..."			

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	Interview on 5/20/11 at 9:15 A.M., the ADON (Assistant Director of Nursing) indicated she was unable to read the result for one blood sugar and incorrect sliding scale coverage for the above results. 3.1-35(g)(2)			
F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to provide effective pain management to control or lessen a resident's severe pain when moved, or turned and positioned in her bed related to an irreparable fractured right hip for 1 of 11 residents reviewed for pain in a sample of 19. Resident: #40 Findings include: Resident #40's clinical record was reviewed on 5/16/11 at 2:35 P.M., and indicated diagnoses of, but not limited to: history of sacral/pelvic fracture, osteoporosis, macular degeneration, senile dementia, and osteoarthritis of the hips.	F0309	**F-309** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:Resident #40 received her scheduled norco at 14:50 on 5/16/11. Resident #40 was reassessed for pain control during the course of the survey with new physician orders obtained. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:A pain assessment was completed for all residents in the facility. Care plans, physician orders and interventions were updated as necessary. *The measures put*	06/23/2011

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	A Physician's Order, dated 5/4/11 at 1:20 P.M., indicated, "Norco 5/325 (Hydrocodone 5mg [milligram]-325 mg APAP [acetaminophen]) tablets. Give i (one) PO (by mouth) TID (three times/day) 6 A.M., 2 P.M., 10 P.M. Keep PRN (as needed) Norco order (every 4 hours) for breakthrough pain...." Resident #40 also had an order for Acetaminophen 650 mg. TID and Tramadol 100 mg. TID. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, Resident #40 was observed lying in her bed. The resident was grimacing and indicated she was having pain at the time. LPN #2 indicated the resident had a recent fall and sustained an irreparable fractured right hip. Resident #40 was observed on 5/16/11 at 12:25 P.M., screaming out in pain when she was pulled up in her bed by LPN #2 and CNA #5. During interview with LPN #2 at the time, she stated, "We need to get some of the PRN (Norco) in her." Review of Resident #40's Medication Administration Record (MAR) on 5/16/11 at 12:30 P.M., indicated she had been		*into place and a systemic change made to ensure the deficient practice does not recur is*: Licensed nursing staff has been in-serviced on assessing and treatment of pain. Other facility staff has been in-serviced to notify the charge nurse for complaints of pain during the provision of care or throughout the course of the day. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with monitoring and treatment of pain. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	medicated with Norco (narcotic pain medication) 5 mg. (milligram) at 6:00 A.M. (scheduled dose). She received 650 mg. of acetaminophen (over the counter analgesic) and 100 mg. of Tramadol (non-narcotic pain medication) at 8:00 A.M. LPN #2 medicated Resident #40 with the PRN (as needed) Norco 5 mg. at 12:30 P.M., for her breakthrough pain. On 5/16/11 at 4:50 P.M., Resident #40 indicated in an interview she was having "bad" pain in her right hip and was fearful of being moved in bed. Review of her MAR, at the time, indicated she had not been given her 2:00 P.M. scheduled dose of Norco. Instead, she received another dose of the 650 mg. acetaminophen and 100 mg. of the Tramadol at 2:00 P.M. She did not receive the PRN dose of Norco until 4:00 P.M. The resident had received a PRN dose at 12:30 p.m. of the Norco. A "Resident Event Report Worksheet," dated 5/3/11, indicated, "...Event date: 5/3/11...Event Nature: Fall with significant injury...Event Adverse effect: Fracture R (right) hip...Pain R hip...Res (Resident) sitting in lounge area on alz (Alzheimer) unit. QMA (Qualified Medication Aide) in a room with another res. and nurse in office on phone. Res.			

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	disengaged personal alarm and stood up to amb (ambulate). Nurse saw this and tried to get to res., but she fell on R side before he could reach her." A Nurse's Note, dated 5/3/11 at 9:30 P.M., indicated, "Res. was sitting in Dayroom. Disengaged her Mobility Monitor. Observed standing in Dayroom got up to go to rm (room). Res. lost bal (balance) et (and) fell to floor on R side...11:00 P.M. -Res. (resident) immobilized on long board et (and) transferred to ER (Emergency Room) for eval (evaluation) and tx (treatment)." A hospital report, dated 5/04/11 at 12:14 A.M., indicated, "...Right inter-trochanteric fracture of the proximal femur (hip), closed...." A Social Service Note, dated 5/17/11 at 1:03 P.M., indicated, "...Was seen by specialist, Dr. (Name), 5/12/11. Physician stated to dtr. (daughter) that surgery was not feasible d/t (due to) deterioration of (Resident #40's) bones (this was told to this writer by dtr. today during visit to her mother)...." Further review of Nurse's Notes indicated the following: "5/2/11 at 2:00 P.M.-Up with assist of one with walker to meals and BR			

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	(bathroom)...5/4/11 at 8:30 P.M.-Res. crying out in pain, grabbing R hip. Norco given after repositioning. Unsuccessful...c/o's (complains of) pain with turning to change pads...agitated with staff while turning. Pain #8-#9 (pain scale 0-10 with 10 being 'worst pain that can be imagined') when moving...5-5-11 at 7:30 P.M.-...Medicated for pain #9 at 6P (P.M.) with Norco...in severe pain when T & R (turned and repositioned)...5-6-11 at 9:00 P.M. -...Cries out loudly grabbing at staff members in severe pain whenever being T & R or ever putting HOB (head of bed) up or down...5/7/11 at 10:50 P.M.-T & R q (every) 2 hours-cries out loudly, grabbing staff arms and clothing-severe pain when being T & R...5/8/11 at 2:00 P.M.-...much discomfort when moved feet up...medicated x 1 between routine Norco dose...5/8/11 at 8:00 P.M.-...cont. (continues) to be in severe pain when turned despite pain meds...5/9/11 at 3:53 A.M.-...Cont. to show s/s (signs and symptoms) of pain when moved. PRN medication given...5/9/11 at 1:45 P.M. -...when res. turned yells out at staff, facial grimacing...5/9/11 at 6:19 P.M. -...yells out with P.M. care, routine and PRN meds given...5/10/11 at 2:00 P.M. -...as long as still no pain on routine pain med...5/11/11 at 2:00 P.M.-...much discomfort when turned...5/11/11 at 9:30			

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	P.M.-...severe pain when care is being given...5/12/11 at 3:50 P.M.-...cont. in pain when T & R...5/12/11 at 7:50 P.M. -...Medicated for pain #9 at 1800 (6:00 P.M.) with some relief obtained-cont. to moan-cry out, tear at staff's clothing when being T & R...5/13/11 at 6:30 A.M. -...Repositioned and changed and the c/o's of Rt (right) hip pain with care...5/13/11 at 2:25 P.M.-...Res. yell (sic) out some in pain when turned or repositioned by ii (2) assist...5/14/11 at 6:00 A.M.-...Resists being turned due to increased Rt leg pain with movement...5/14/11 at 9:22 P.M. -...severe pain when T & R (moaning, crying out, tearing at clothing)...5/15/11 at 7:30 P.M.-...uncomfortable when T & R...5/16/11 at 2:50 P.M.-...Routine pain meds as ord. (ordered), during repositioning after lunch res. pulled up in bed, yelling out, "My leg, No No," was given PRN med at 12:30 with lunch then routine pain meds at 1400 (2:00 P.M.) et Norco routine at 1450 (2:50 P.M.), during incont. (incontinence) care et repositioning seemed much more comfortable...5/17/11 at 2:00 A.M. -...Yelling out with pain...." The Nurse's Notes lacked documentation to indicate the physician had been notified of the ongoing pain. During interview with Resident #40 on 5/17/11 at 9:10 A.M., she indicated she			

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	was having pain in her right hip, but was unable to rate her pain on the 0-10 pain scale. The MAR indicated a scheduled Norco 5 mg. had been given to Resident #40 at 6:00 A.M., but did not control her pain. Review of the Nurse's Notes indicated, "5/17/11 at 3:45 P.M.-...Yells out when moved...5/17/11 at 9:45 P.M.-Resident has lots of pain with any movement...5/18/11 at 10:00 A.M.-...Res. c/o pain R hip. Pain when pulled up in bed with 2 assist. Dr. (Name) called with report et notified. New order received...." Resident #40's MAR indicated she received the PRN (as needed) Norco for breakthrough pain on the following dates and times: 2 times (x's) on 5/04/11: 12:30 and 8:30 P.M. (no routine Norco given on 5/04/11); 1 x on 5/05/11: 6:00 P.M.; 3 x's on 5/06/11: 2:00 A.M., 10:00 A.M., and 6:00 P.M.; 1 x on 5/07/11: 10:15 A.M.; 3 x's on 5/08/11: 2:00 A.M., 10:00 A.M., and 6:00 P.M.; 1 x on 5/09/11: 2:00 A.M.; 1 x on 5/11/11: 6:00 P.M.; 1 x on 5/13/11: 6:00 P.M.; 1 x on 5/14/11: 6:00 P.M.; 2 x's on 5/16/11: 12:30 P.M. and 4:00 P.M.; 1 x on 5/17/11 at 2:00 A.M. Resident #40 received a total of 17 doses of the PRN Norco (for breakthrough pain) over the 15 day period of 5/04/11 through 5/18/11.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	The Director of Nursing (D.O.N.) indicated in an interview on 5/18/11 at 11:15 A.M., a Physician's Order had been obtained for Morphine Sulfate (a strong, fast-acting pain narcotic) 5 mg. to be administered every two hours for breakthrough pain. "The Vicodin (Norco) wasn't controlling her pain. We were using the PRN Vicodin, but it wasn't doing the job. We just gave her a dose of the morphine to help control her pain. We are going to reposition her in about 30-35 minutes to see how she does." A Physician Order, dated 5/18/11, indicated, "Morphine Sulfate Suspension 20mg/ml (milliliter) give 5 mg. PO or sublingual Q 2 hrs (hours) for breakthrough pain." During observation of Resident #40 on 5/18/11 at 11:35 A.M., CNA #15 and the D.O.N. were observed providing incontinence care. CNA #15 reached across the bed, grabbed Resident #40's right femur (large thigh bone) and pulled Resident #40 towards her while the D.O.N. pushed on Resident #40's right hip to aid in turning her onto her left hip. Resident #40 moaned slightly, but did not scream out in pain. CNA #12 and CNA #14 were observed providing incontinence care to Resident			

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	#40 on 5/19/11 at 1:10 P.M. Resident #40 moaned when the head of her bed was lowered to a flat position and screamed out in pain when her legs were touched. Resident #40 was rolled onto her right hip so she could be washed. She screamed out in pain as she was rolled. CNA #14 then reached across the bed and pulled on Resident #40's right thigh while CNA #12 pushed on her right hip to turn her over onto the left hip. Resident #40 screamed out in pain and yelled "My leg. My leg. No. No." During interview with the D.O.N. on 5/19/11 at 1:35 P.M., she indicated staff wanted to control Resident #40's pain, but did not want to "snow" her. When queried why the doctor had not been notified of the situation, the D.O.N. indicated she was going to consult a "palliative care" physician to evaluate Resident #40 and suggest treatment to control her pain. Resident #40's Care Plan, dated 5/10/11, indicated, "Problem: Fracture: Right Hip Resident Fall. Goal: Resident will have no complications and minimal pain from hip fracture. Approach: ...Administer pain medication as ordered and check for effectiveness and notify doctor if resident not getting relief...." A facility policy titled "Pain			

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	Management," revised 4/28/09, indicated, "Policy: The center's practice is to assist each resident with pain or that has a potential for pain to maintain or achieve the highest practicable level of well being and functioning through pain management...6. The center provides orientation and ongoing staff education to correct misconceptions, myths, and biases about pain. Training my (sic) include, but is not limited to: ...b. recognizing and assessing pain, reporting and documenting findings, and monitoring interventions...." 3.1-37(a)			
F0312 SS=E	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observations, interview and record review, the facility failed to ensure residents needing assistance with grooming and personal hygiene received that assistance related to residents observed with facial hair and urine soaked clothing for 3 of 3 resident in a sample of 19 (Resident # 58, #35, #3) and for 4 of 4 residents in a supplemental sample of 30. (Residents: #20, # 51, #49 and # 60.) Findings include: 1. Resident # 58's record was reviewed on	F0312	**F-312** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:Resident's #20, #51 and #58 facial hair grooming issues were resolved during the course of the survey. Resident #60's preferences related to retaining facial hair will be honored. Resident #35, #49, #3 were provided with incontinence care	06/23/2011

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	5/16/11 at 10:20 a.m. The Resident's record indicated diagnoses of, but not limited to: dementia with behaviors, hip fracture, osteoporosis, kyphosis and seborrhea dermatitis. During a tour of the dining room on 5/16/11 at 8:30 a.m., an observation was made of Resident # 58 sitting at a table with other resident's. Resident # 58 was observed to have long curly facial hair on her upper lip and chin. Review of Resident # 58's quarterly MDS assessment, dated 5/2/11, indicated she needed limited assistance with one staff assistance for hygiene and bathing. The Resident's plan of care dated 2/7/11, indicated "Requires physical assist with ADL's...Approach: Set up equipment for daily hygiene and provide cues for upper body tasks. Assist after she has tried...." 2. Resident # 20's record was reviewed on 5/18/11 at 4:45 p.m. The record indicated diagnoses of, but not limited to; Alzheimer's disease, hypertension, and depressive disorder. During a tour of the facility on 5/16/11 at 7:00 a.m., Resident # 20 was observed up and dressed. His face was observed to have several days of facial hair growth.		at the time of observation. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:The facility validated that residents are free of unwanted facial hair. All residents are being monitored for appropriate and timely incontinence care. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: All nursing staff has been in-serviced related to grooming to include ensuring residents are free of unwanted facial hair and provision of incontinence care. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with grooming/facial hair. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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Resident # 20's plan of care updated 5/10/11 indicated "Discharge not feasible related to; ...dementia, unable to care for self...Approach...provide care and services daily...." The Resident's record lacked a plan of care to address his grooming and shaving needs.

During an interview at that time with the ADON (assistant director of nursing) she indicated the resident could do much for himself but needed cueing at times. She indicated the resident was very confused and was a wander risk.

3. Resident # 51's record was reviewed on 5/18/11 at 5:15 p.m. The resident's record indicated diagnoses of, but not limited to; diabetes, renal failure, peripheral vascular disease, hypertension, and depression.

During a tour of the dining room on 5/16/11 at 8:30 a.m., an observation was made of Resident # 51 sitting at a dining table with other residents. Observation was made of her chin covered with a heavy growth of gray hairs.

The Resident's quarterly MDS (minimum data set) assessment, dated 4/11/11, indicated the resident required extensive assistance with two staff assistance with

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	personal hygiene. The resident's plan of care, dated 5/16/11, indicated " Problem; Requires physical assist of staff for ADL's (activities of daily living)...." The Resident's plan of care failed to indicate to keep her face free from chin hair. 4. Resident # 60's record was reviewed on 5/18/11 at 5:40 p.m. The Resident's record indicated diagnoses of, but not limited to; obstructive hydrocephalus; mental disorder, hypertension, impaired renal function, and obsessive compulsive disorder. During a tour of the dining room on 5/16/11 at 8:30 a.m., an observation was made of Resident # 60 sitting at a dining table with other residents. Observation was made of the resident to have a large amount of facial hair. Long curly hairs above her lip and on her chin was observed. The Resident's plan of care updated 3/8/11 indicated "Problem: Alert and oriented with increased forgetfulness and confusion, needing reminders and prompts...." A are plan, dated 3/2/11, indicated "Problem; discharge not feasible...Approach indicated to provide care and services daily.			

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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5. Resident #35's clinical record was reviewed on 5/19/11 at 10:45 A.M., indicated diagnoses of, but not limited to: Alzheimer's dementia with behavioral disturbance, bipolar disorder, and delusional disorder.

During initial tour of the facility on 5/16/11 at 7:00 A.M., while accompanied by LPN #2, she indicated Resident #35 had behaviors, was confused, incontinent, and a two person assist.

Resident #35 was observed on 5/16/11 at 11:55 A.M., sitting in a recliner in the central living area of the dementia unit. His sweat pants were wet, indicating he was incontinent of a large amount of urine.

During observation of a medication administration pass on 5/16/11 at 5:20 P.M., LPN #29 indicated Resident #35 was in the bathroom. She opened the door of the restroom, which was located immediately off of the dining room, with two visitors having full view of the bathroom commode on which Resident #35 was seated with his pants down.

On 5/18/11 at 4:25 P.M., Resident #35

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	155474	A. BUILDING 00 B. WING	05/24/2011

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	was observed in the recliner in the central living area of the dementia unit. He had his socks and shoes off and his bare feet dangled off to the left side of the footrest. His pants were soiled with urine. During interview with Social Service/Director on 5/18/11 at 4:35 P.M., she indicated she could not toilet Resident #35 by herself and the other staff person was busy with other residents. 6. During initial tour of the dementia unit on 5/16/11 at 7:00 A.M., while being accompanied by LPN #2, Resident #49 was observed in her room. She was identified as being incontinent Her night clothes and all of her bed linens were urine soaked, at the time, and CNA #5 indicated Resident #49 was to be showered. CNA #5 was observed escorting Resident #49 for her shower at 7:40 A.M. Resident #49 was observed seated at the dining room table on 5/16/11 at 11:45 A.M. A strong urine odor surrounded her. CNA #5 and LPN #2 assisted her to the bathroom. Her slacks had a large wet area on the backside indicating she had been incontinent of a large amount of urine. LPN #2 indicated in an interview on 5/16/11 at 11:50 A.M., that many of the			

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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residents on the unit were incontinent and needed assistance with toileting. She further indicated there was a limited amount of staff on the unit and it made it difficult to provide the necessary care for residents requiring two person assist.

7. Resident #3's clinical record was reviewed on 5/19/11 at 2:00 P.M., and indicated diagnoses of, but not limited to: dementia, history of right femur fracture, depression, and constipation.

Resident #3 was observed sitting in her wheel chair across from the nurse's station at 4:10 P.M. on 5/16/11. She smelled of a strong urine odor. The odor was brought to the attention of CNA #30 who immediately took Resident #3 to her room.

CNA #30 and LPN #25 were observed transferring Resident #3 to her bed via a mechanical lift at 4:20 P.M., (5/16/11). Resident #3's slacks were wet with urine but her incontinence brief was dry upon investigation. Further investigation of the source of odor indicated a large pool of urine underneath her pressure reducing cushion in her wheel chair. The top and bottom of the cushion were wet with urine.

During interview with LPN #25, at the

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	time of the observation, she indicated staff neglected to properly clean the wheel chair after providing her with previous incontinence care. A form titled "Care Plan Conference Summary" dated 3/8/11, indicated "Plan of Care: Nursing: Supervision ADL's...." The Resident's record lacked a plan of care addressing bathing and grooming needs. 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to prevent the development of multiple or recurrent stage II pressure ulcers for 3 of 3 residents reviewed for pressure ulcers in a sample of 19.	F0314	**F-314** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been*	06/23/2011

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	Residents: # 54, # 80, # 92 Findings include: 1. The clinical record for Resident # 80 reviewed on 5/16/11 at 10:45 A.M., indicated diagnoses of, but not limited to, diabetes mellitus, acute kidney failure, stage II pressure ulcers, and peripheral neuropathy. During initial tour on 5/16/11 at 6:35 A.M., accompanied by LPN # 16, she indicated that Resident # 80 was a diabetic with open areas to both her heels. She indicated that she was using heel cushions and heel boots and that she was currently seeing a wound specialist. Resident # 80's readmission date was 1/11/11. Resident # 80's initial MDS (Minimum Data Set), dated 1/21/11, indicated "...bed mobility...extensive assistance...one person physical assist...transfer...extensive assistance...two person physical assist..." A Resident Progress Note, dated 3/4/11 at 1200 (12:00 P.M.), indicated, "8 x 7 intact blister to L (left) heel et. (and) bottom of foot. Bottom of foot purple in color. Possible deep tissue injury. Dr. (Name) notified for tx. (treatment) request et. vitamin supplements...."		*affected by the deficient practice was*:Resident #80's right heel is now healed and the area to the left heel has significantly decreased in size. The heelz up cushion has been amended to help stabilize the location in the bed in order to maintain flotation of heels. Resident #54's area to left buttocks is now healed. Resident #92's care plan has been updated to include preventative measures related to history of heel ulcers. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:The facility has reviewed all care plans to ensure appropriate preventative measures are reflected for each resident indentified to be at risk. The care plans were revised as needed. A full facility review of Braden Scale was conducted and all found to be current. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Nursing staff along with therapy, activity staff, and department managers has been in-serviced on preventative measures including the proper placement of the heelz up cushion/pillows to elevate heels of the bed. All licensed staff has been in-serviced on pressure ulcer care plans and pressure ulcer prevention care plans. *To ensure the deficient practice does not recur, the monitoring system*	

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	A "Weekly Pressure Ulcer Condition Report", dated 3/4/11, indicated, "...location...heel & bottom of L foot...date of first observation 3/3/11...Size 8 x 7...Stage/Depth...Stage II - Partial thickness skin loss involving epidermis &/or dermis...Skin Color Surrounding Wound...Bright red &/or blanches to touch...5/19/11...Size 2.8 x 2.8...Unstageable...Skin Color...Bright red &/or blanches to touch..." A Resident Progress Note, dated 3/6/11 at 0530 (5:30 A.M.), indicated, "During AM care it was noted that res. (resident) has an area on the R (right) outer aspect of heel measuring 3.6 x 3.0. Res. c/o (complaining of) pain if area was touched. PRN (as needed) Tylenol (pain medication) given at this time. MD (Medical Doctor) notified of area, tx. requested. ADON (Assistant Director of Nursing) notified. Therapy notified...." A "Weekly Pressure Ulcer Condition Report", dated 3/6/11, indicated, "...location...heel Right...date of first observation 3/6/11...Size 3.6 x ...Stage/Depth...Stage II - Partial thickness skin loss involving epidermis &/or dermis...Skin Color Surrounding Wound...Pink...5/19/11...Size 1.5 x 2.0...Stage II...Skin Color...Pink..."		*established is*:A Performance Improvement indicator has been established which evaluates compliance with proper placement of heelz up cushions/pillows and to monitor care plans related to pressure ulcers. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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A Resident Progress Note, dated 3/10/11 at 0820 (8:20 A.M.), indicated, "Wound nurse measured et. assessed et. Dr. (Name); stage II pressure ulcer 8.2 x 7.4 x skin intact L heel et. stage II R heel 2.4 x 3.0 x skin intact. Proderm applied to both areas. No odor, drainage. Minimal swelling noted bil (bilateral) ankles et. tops of feet....use airboots at all times....Preventative measures...keeps heels a float..."

Review of a "Wound Consult Note," dated 3/10/11, indicated, "I was asked to see the patient for wound care due to blisters on both heels, the left worse than the right. These apparently have come up spontaneously recently....We will obtain noninvasive arterial studies with toe pressures...."

A "Vascular Flow Study," dated 3/15/11, indicated, "...Absolute toe pressures right lower extremity...this suggests adequate arterial perfusion for wound healing....Absolute toe pressures...left foot digits, which suggests adequate arterial flow for wound healing...."

Review of a "Nursing Home Visits/Home Care," dated 4/16/11, indicated, "She has had healing of the heel ulcer...We'll aggressively try and prevent further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pressure sores...." A "Wound Care Note," dated 4/22/11, indicated, "...The patient's non-invasive arterial studies appears to show circulation to be adequate for healing...." During observation of Resident # 80's stage II pressure ulcers on 5/20/11 at 1:50 P.M., LPN # 9 uncovered Resident # 80's feet. The Heelz up cushion was underneath the resident's thighs. The resident was wearing airboots which were resting on the bed. The right heel was purplish, red in color with no open area. The left heel wound appeared the size of a quarter with a dark black center (eschar). On 5/20/11 at 9:15 A.M., the ADON indicated they are unsure why Resident # 80 developed pressure ulcers. Interview with LPN # 9 on 5/20/11 at 1:50 P.M., she indicated Resident # 80's heels are to be kept up off the bed when she is in bed. She further indicated the Heelz up cushion slides around and doesn't stay under her legs. A Care Plan, initiated 3/4/11, updated 4/19/11, indicated, "...Problem...Stage II pressure ulcer with possible deep tissue injury L heel et. bottom of L foot...Approach...Keeps heels a			

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	155474	A. BUILDING 00 B. WING	05/24/2011

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	float...Heez (sic) up cushion to bed..." Another Care Plan, initiated 3/7/11, updated 4/19/11, indicated, "...Problem...Stage II R heel with possible deep tissue injury ...Approach...Keeps heels a float in bed...Heez (sic) up cushion to bed..." 2. Resident # 54's record was reviewed on 5/18/11 at 8:50 a.m. The Resident's record indicated diagnoses of, but not limited to; cerebral vascular accident with right hemiplegia, dementia, and osteoporosis. During an interview on 5/16/11 at 7:00 a.m., with the ADON (Assistant Director of Nursing) regarding Resident # 54's skin condition, she indicated the resident had no skin problems or open areas and received total care. The Resident's record indicated she developed a pressure ulcer on 4/16/11 on her left buttocks. Nurses note, dated 4/16/11 at 6:50 a.m., indicated " Resident found with 0.1 cm (centimeter) by 0.1 cm, < (less than) 0.1 cm D (depth). Open area no c/o (complaints of) Requested tx (treatment) and to be measured wkly (weekly) until healed...." The record indicated on 4/23/11 the pressure area was healed.			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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Review of nurse note dated 5/17/11 at 7:34 a.m., indicated "...resident has a 0.6 by 0.5 cm area to to (sic) lt (left) side of buttocks. MD (medical doctor) was notified via fax and tx (treatment) requested."

A care plan, dated 3/15/10 and updated on 4/5/11, indicated "Problem: At risk for skin breakdown, impaired mobility... Goal; Will be clean, dry and free of skin breakdown...Approach; Assist to reposition frequently, (Resident) chooses not to lay down between meals, peri care and moisture barrier after each incontinence, alternating air pressure mattress on bed, pressure relief cushion in W/C (wheelchair).

A care plan, dated 3/15/10 and updated on 4/5/11, indicated "Problem: At risk for skin breakdown..." A plan of care dated 3/15/11 and updated on 4/5/11, indicated "Problem: Significant weight loss (March 2010) Leaves 25% or more uneaten most meals, at risk for choking, dx (diagnosis) hiatal hernia, dx: dysphagia....Approach: ...Notify RD (registered dietitian) and MD (medical doctor) of significant weight changes, abnormal labs, skin breakdown...."

The Resident's quarterly MDS (minimum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	data set) assessment, dated March 3, 2011, indicated she transferred with a Parker lift and 2 assistance of staff and used a wheelchair for mobility. The Resident needed total assistance for bathing and dressing. May 2011's Meal Intake Record for Resident # 54 indicated she refused many of her meals and the alternates. May 4th through the 9th, the resident refused her dinner meals and the alternates. The Resident's meal intake for the month of May was less than 25%. Nurses notes for May 2011 lacked documentation to indicate the dietitian or the physician had been notified of the resident not eating for several days in a row. The resident's record indicated the dietitian updated a note on 5/19/11 after a resident record review. The dietitian's note failed to indicate the resident had an open area. 3. Resident #92 record was reviewed on 5-19-2011 at 1:55 p.m. Resident #92's diagnoses include, but were not limited to, dementia, peripheral neuropathy, edema, and hemiplegia. Resident #92 was admitted to facility on 7/29/2008 and has used a power chair for			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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mobility.

The "Resident Progress Notes," dated 1/4/11 at 8:20 a.m., stated, "Res (resident) was found c (with) 2 new bruises this am (morning), on back of heels bilaterally. R (right) bruise measures 1.2 c.m. x 0.5 c.m., L (left) bruise measures 1 c.m. x 0.4 c.m...."

The "Weekly Pressure Ulcer Condition Report," stated, "...date of first observation 1/4/11...Assessment 1/4/11...stage 1...edges distinct...white/gray non-variable tissue &/or non-adherent yellow...necrotic tissue...non visible...exudate amount...1-none...."

The "Weekly Pressure Ulcer Condition Report," stated, "...date 1/21/11...stage 2 blister...."

The "Physician's Orders," dated 1/5/10 stated, "...Proderm to bilateral heels TID (three times a day) until healed..."

The "Comprehensive Care Plan Report," updated on 5/3/11, indicated that Resident #92 was, "...At risk for skin breakdown...Will be clean, dry & free of skin breakdown...." There was no documentation regarding prevention or treatment of the bilateral heel pressure

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	sores. An interview was conducted on 5/19/11 at 4:45 p.m. with LPN #3. LPN #3 was unable to find a care plan addressing prevention or care of heel pressure ulcers. LPN #3 indicated that the documentation should be on the chart. The policy titled, "Pressure Ulcer Prevention" dated 4/28/09 was reviewed on 5/24/11 at 3:40 p.m. stated, "Policy- A resident who enters the center without pressure ulcers and/or other non-pressure ulcers does not develop pressure ulcers and/or other non-pressure ulcers, unless the individual's clinical condition demonstrates that they were unavoidable. The center provides care and services to: a. Promote the prevention of pressure ulcer development b. Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and c. Prevent development of additional pressure ulcers...15. Develop care plan on the degree and areas of risk and update as necessary...." 3.1-40(a)(1) 3.1-40(a)(2)			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview, and record review, the facility failed to ensure resident's bodies were kept elevated at 30 degrees to protect residents from potential complications while receiving gastric tube feedings. This deficient practice affected 2 of 2 residents in a sample of 19 and 1 of 1 residents in a supplemental sample of 30 receiving tube feedings. (Resident #27, 28, 10) Findings include: 1. Resident #27's record was reviewed on 5/16/11 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. On 5/16/11 at 6:34 a.m., Resident #27 was observed with the head of the bed below thirty degrees while his continuous tube feeding was running at 65 cc/hour. An interview was conducted with the ADON (Assistant Director of Nursing) on	F0322	**F-322** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: Resident's #10, #27 and #28 were immediately repositioned as per facility policy for residents receiving gastric feedings by elevating the head of bed at a 30 to 45 degree angle and ensuring appropriate resident positioning in the bed. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No other residents were found to be affected by this practice as no other residents in the center receive gastric feedings. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Nursing staff have been in-serviced related to the facility policy for residents receiving gastric feedings to include maintaining the bed at 30-45	06/23/2011

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	155474	A. BUILDING 00 B. WING	05/24/2011

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	5/16/11 at 6:34 a.m. The head of the bed was verified below 30 degrees. Also indicated that the head of the bed should be between 30 and 45 degrees. On 5/16/11 at 5:45 p.m., Resident #27 was observed with the head of the bed at 30 degrees but the resident slid down in bed in a position lower than 30 degrees. An interview was conducted with RN #8 on 5/16/11 at 5:45 p.m., indicated that he checks Resident #27 hourly but the staff just can not prevent the residents from sliding down in bed. 2. Resident #28's record was reviewed on 5/16/11 at 11:30 a.m. Resident #28's diagnoses include, but were not limited to, severe brain injury, seizures, and dysphagia. On 5/16/11 at 6:34 a.m., Resident #28 was observed with the head of the bed below thirty degrees while his continuous tube feeding was running. ADON adjusted his position after entering the room with this surveyor. An interview was conducted with the ADON (Assistant Director of Nursing) on 5/16/11 at 6:34 a.m. The head of the bed was verified below 30 degrees. Also indicated that the head of the bed should		degree angle and to include ensuring that residents have not slid down in the bed. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with positioning of G-tube residents in the bed and the head of bed elevated at a 30-45 degree angle. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	be between 30 and 45 degrees. 3. Resident # 10's record was reviewed on 5/16/11 at 10:00 a.m. The Resident's record indicated diagnoses of, but not limited to; stroke, gastric tube, diabetes, dysphagia and aphasia. The Resident's record indicated she receives gastric feedings by way of a pump at 45 cc (cubic centimeter) and hour continuously. The Resident's record indicated "Aspiration alert" on the physician's order sheet. During a tour of the facility on 5/16/11 at 7:35 a.m., Resident # 10 was observed in her bed with her body flat. The resident's bed was raised, but the resident had slid down in the bed placing her body in a flat position. The resident's feeding pump was observed hooked up to the resident's gastric feeding tube with the pump observed running at 45 cc's (cubic centimeters) an hour. During an interview with the ADON at that time, she indicated the resident should have been placed higher in the bed. A care plan, dated 2/1/11 and updated on 4/19/11, indicated " Problem; ...Feeding			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	tube- NPO (nothing by mouth)...Approach; Keep HOB (head of bed) elevated 30 degrees at all times...." The plan of care lacked an intervention to ensure the Resident's body is elevated at 30 degrees at all times. Review of the facility's policy and procedure titled "Physician's orders for Enteral Feedings," dated 10/31/10, indicated "...4. Elevation of head of bed 30 to 45 degrees...." 3.1-44(a)(2)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide the necessary supervision to prevent a fall which resulted in an irreparable fractured hip (Resident #40) for 1 of 5 residents reviewed for falls in the sample of 19, failed to provide supervision to prevent resident to resident altercations (Residents: #45, #58, #68) for 1 of 1 residents in the sample of 19 and 2 of 2 residents in the supplemental sample of 30 reviewed for incidents. The facility	F0323	**F-323** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:Resident #40 fell in direct observation of staff however they were unable to get to her in time to prevent the fall. Preventative measures were in place at the	06/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	also failed to provide a hazard free environment related to unsecured steak knives and unsecured barrels containing soiled linens and soiled incontinence briefs. This hazard had the potential to affect 10 of 79 residents observed wandering on the North and South units and 15 of 15 residents residing on the dementia unit. Findings include: 1. Resident #40's clinical record was reviewed on 5/16/11 at 2:35 P.M. and indicated diagnoses of, but not limited to: history of sacral/pelvic fracture, osteoporosis, macular degeneration, senile dementia, and osteoarthritis of the hips. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, she indicated Resident #40 had sustained an irreparable fractured right hip from a recent fall on the unit. Resident #40 had facial grimacing and indicated she was having pain at the time. A "Resident Event Report Worksheet," dated 5/3/11, indicated, "...Event Nature: Fall with significant injury...Event Adverse effect: Fracture R (right) hip...Pain R hip...Res (Resident) sitting in lounge area on alz (Alzheimer) unit...."		time of the fall, and resident had never disengaged the alarm prior to fall. Resident #58 was immediately separated from the other resident at the time of the altercation. Resident #68 was immediately separated from the unidentified male resident. Resident #45 was immediately separated from the other resident, assessed by licensed nurse, physician notified and orders received. Linen barrels were secured in a manner in which residents can not access contents of the barrel and the steak knives have been removed from the rehabilitation room. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:All areas of the center were reviewed to ensure no other potential hazards were present. Additional staffing has been allocated to the dementia unit during both day and evening shifts to enhance supervision of residents. No other residents were found to be affected by these practices. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Facility staff was educated on ensuring that potential hazards are identified and safety practices are maintained. Additional staff have been allocated to the dementia unit and have been educated on vigilance in supervision. *To ensure the*	

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	The report indicated Resident #40 was left unsupervised in the central living area of the dementia unit. "QMA (Qualified Medication Aide) in a room with another res. and nurse in office on phone. Res. disengaged personal alarm and stood up to amb (ambulate). Nurse saw this and tried to get to res., but she fell on R side before he could reach her." LPN #3 indicated in an interview on 5/17/11 at 3:00 P.M., Resident #40 fell next to the small sofa. "There were two staff on duty, but they were busy at the time of the fall." During observation of the dementia unit on 5/16/11 at 8:00 A.M., the nurse's station was observed to have a windowed wall separating the nurse from Resident #40 at the time of the fall. Review of Nurse's Notes indicated the following: "5/2/11 at 2:00 P.M.-Up with assist of one with walker to meals and BR (bathroom)...5/3/11 at 9:30 P.M.-Res. was sitting in Dayroom. Disengaged her Mobility Monitor. Observed standing in Dayroom got up to go to rm (room). Res. lost bal (balance) et (and) fell to floor on R side...." "Post Fall Evaluations" indicated Resident		*deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with safety monitoring and supervision of residents to assist in reducing the likelihood of resident events. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	#40 sustained previous falls: 6/09/10 at 1:55 A.M.-Res (resident) found sitting on the floor with feet on the floor and knees up with pants and brief at her ankles...Fall History...5/23/10...; 7/17/10 at 11:40 A.M. -Resident in dining room. Went to get up from chair, lost balance...did not hit head, has been unsteady on feet lately...; 2/19/11 at 7:45 P.M.-Found sitting on floor in front of chair...Location of resident prior to fall: wheel chair...; 3/5/11 at 7:45 P.M. -Found sitting on floor in front of DR (dining room) bathroom...." A Care Plan, dated 5/02/11, indicated, "Problem: At risk for falls...non-compliant with safety measures secondary to Dementia diagnosis/ Goal: Will be free from falls with injury. Approach: ...assist with ambulation and transfers. Mobility monitor on while up and in chair...." 2. Review of the Resident to Resident incidents of abuse, dated 7/9/10, indicated, Date of Alleged incident - 7/3/10 at 12:30 P.M., Resident # 58 was slapped on the right side of her face by another resident who was supposed to be on 1 on 1 supervision at the time, however, the nurse providing 1 on 1 was on the telephone at the time of the incident.			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	3. Review of the Resident to Resident incidents of abuse, dated 8/8/10, indicated, Date of Alleged incident - 8/7/10, untimed, RN # 38 was walking down the south hallway towards the nurses station when she saw Resident # 68 right leg being held down by another resident with his right hand as he hit her with his left hand. 4. Review of the Resident to Resident incidents of abuse, dated 10/23/10, indicated, Date of Alleged incident - 12/20/10, untimed, Resident # 45 suffered a fall and bruise to the right forearm. The nurse on the unit was in the lounge area when she heard Resident # 45 yell, "Get out of here". As she started towards the room, she heard the Resident say, "Stop pushing me, you're going to make me fall." When the nurse entered the room, she saw Resident # 45 on the floor of her room with a male resident standing over her. A facility policy titled "Abuse", revised 10/31/09, indicated, "Verbal...physical...and neglect of the resident...are strictly prohibited....Prohibitions on abuse apply to...residents...Identify residents most at risk of neglect and abuse, may include...Residents who have			

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	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	dementia...psychosocial, interactive, and/or behavioral dysfunction...." 5. During an environmental tour of the facility on 5/20/11 at 2:30 p.m., accompanied by the Maintenance Director # 41 and the Housekeeper # 42, an observation was made of the Occupational Therapy room door open. In the room an observation was made of 2 serrated steak knives in a basket in an unlocked cupboard. An observation was made of 10 residents wandering unsupervised. There wasn't any staff member present in the Occupational Therapy room. Residents pass by the Occupational Therapy room to visit the Therapy Department on a daily basis. In the unlocked Alzheimer's unit bathroom that is used by the residents, an observation was made of two large 50 gallon containers. The containers were marked, one was for trash the other was for soiled linen. The large containers had a plastic lid that could easily be lifted off. Alzheimer's residents freely use this bathroom, the bathroom door was observed to be left open. During an interview with CNA # 28 on 5/20/11 at 2:50 p.m. regarding the two			

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	large containers accessible to residents, she stated "I wouldn't want my parents near those, they could get into them and they are contaminated." 3.1-45(a)(1) 3.1-45(a)(2)			
F0325 SS=G	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observations, interviews and record review, the facility failed to ensure a resident maintained a normal weight related to a resident losing a significant amount of weight in one month (28.6 pounds) and by not putting an immediate intervention in place to aid in nutrition for 1 of 6 residents reviewed for weight loss in a sample of 19. (Resident # 54) Findings include: Resident # 54's record was reviewed on 5/18/11 at 8:50 a.m. The Resident's record indicated diagnoses of, but not limited to; cerebral vascular accident with right	F0325	**F-325** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The dietician, physician, and POA were informed of the resident #54's weight loss on 5/19/2011. New orders were received to increase house supplement. Resident #54's weight has increased from 126.9 lbs. to 130.1 lbs. After discussion with family about resident #54's current condition, the decision	06/23/2011

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	hemiplegia, dementia, and osteoporosis. A physician's order, dated 1/27/10, indicated "Pureed diet with nectar thick liquids. A physician's order, dated 2/2/11, indicated " House supplement 2.0 calorie give 60 cc (cubic centimeter) by mouth daily. DX (diagnosis) Nutritional supplement. The Resident's form titled "Individual Resident Weight History" indicated the weights on the following dates: 1/9/11- weight was 141 2/9/11- weight was 155.2 3/6/11- weight was 156.7 4/11- weight was 155.5 5/11- weight was 128.5 the reweight was 126.9 Total weight loss from April to May was 28.6 pounds. Nurses notes, dated 4/17/11 to 5/15/2011, lacked documentation indicating the physician had been notified of the significant weight loss for May so further physician intervention and orders could be obtained. The Resident's plan of care, dated 3/15/10, indicated "Problem: Significant weight loss (March 2010) Leaves 25% or more uneaten most meals, at risk for		was made for Hospice to evaluate resident #54. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:Residents identified as having significant weight loss for the month of June received necessary follow-up with physician and dietician. An immediate intervention has been put into place and reflected on the resident's plan of care. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Residents at risk for weight loss will be identified through the weekly resident at risk meeting. Ongoing evaluation and weight monitoring will occur to ensure timely and appropriate intervention. Licensed nursing staff re-inserviced regarding physician notification related to change of condition. The facilities dietician was in-serviced by the regional dietician related to updating care plans for weight loss. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with care plans related to weight loss. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility	

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	choking Dx (diagnosis) Hiatal Hernia, Dx: Dysphagia...Approach:...Notify RD (Registered dietitian) and MD (Medical Doctor) of significant weight changes...." The Resident's record lacked documentation indicating the Dietitian had been notified of the significant weight loss so an intervention could have been put in place immediately. The resident's record was reviewed on 5/18/11 at 8:50 a.m., with a concern shared for weight loss. On 5/19/11, the resident's record indicated a note from the Dietitian was added to the resident's record. The Dietitian's note acknowledged the recent significant weight loss and to increase the House Supplements and add weekly weights to monitor...." The resident's form titled "Individual Resident Meal Intake Record" dated March 2011, indicated the Resident was eating greater that 25% of her meals for breakfast. For lunch and dinner her intake averaged 25% of her meals. The March documentation for the a.m. and p.m. snacks indicated the Resident consumed nearly all of the food and fluids offered. The Resident's form titled "Individual Resident Meal Intake Record" dated April		performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	2011, indicated from April 9th to the 15th, the resident had refused her supper and also the alternate. The resident's record lacked documentation to indicate the dietitian or the physician had been notified. On April 28th the form indicated Resident # 54 refused all three meals that day. The April meal intake form indicated for the entire month of April, her intake was less than 25% with refusal of many of the meals and alternates. The nurses notes lack documentation to indicate the physician or the dietitian had been notified so further interventions could have been tried. May 2011's Meal Intake Record for Resident # 54 indicated she refused many of her meals and the alternates. May 4th through the 9th, the Resident refused her dinner meals and the alternates. The Resident's meal intake for the month of May was less than 25%. Nurses notes for May 2011 lack documentation to indicate the dietitian or the physician had been notified of the Resident not eating for several days in a row. The Resident's record indicated Resident # 54 needed extensive assistance with meals.			

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	On 5/17/11 at 1:00 p.m., Resident # 54 was observed in the dining room. The resident was observed refusing to eat her pureed lunch. Observation was made of staff attempting to assist the Resident with her meal, she refused to eat. No alternative was observed being offered. Staff was observed to give up quickly when the resident refused to eat. During an interview with CNA # 5 on 5/17/11 at 1:20 p.m. regarding resident # 54 not eating, she indicated it was difficult for staff to get her to eat. During an interview with the Director of Nursing on 5/19/11 at 5:00 p.m., regarding weight loss for Resident # 54, she indicated it should have been addressed more timely. The facility's policy titled "Nutritional Risk, Nutritional Problem and/or Significant Change" dated 10/31/10, indicated "...Significant Change, a decline or improvement in a patient's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard diseased-related clinical interventions, is not "self-limiting", b. Impacts more than one area of the patient's health status; and c. Requires interdisciplinary review of the care plan ...."			

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F0328 SS=G	3.1-46(a)(1) The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, the facility failed to perform the necessary suctioning to adequately clean the airway of a medically compromised and totally dependent resident with copious amounts of secretions which resulted in the resident violently coughing and struggling for breath. This deficient practice affected 1 or 1 residents receiving suctioning in a sample of 19. (Resident #27) Findings include: Resident #27's record was reviewed on 5-16-2011 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. Resident #27 was admitted with a	F0328	**F-328** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:Resident #27 is able to mobilize secretions independently and does not require frequent suctioning. His oxygen saturation level was between 84% and 93% during the suctioning procedure on 5/16/11. Licensed nursing staff was in-serviced on tracheostomy care and suctioning immediately during the survey by the Staff Development Coordinator and the Respiratory Therapist. There were no negative outcomes to resident #27 related to tracheostomy care. *The corrective action taken for*	06/23/2011

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	tracheostomy on 10/06/2003. On 5/16/11 at 6:11 p.m., RN #6, RN #7, RN #8, and ADON were observed cleaning and repositioning Resident #27. Resident #27 was observed with a tracheotomy and oxygen at 4 liters delivered through tracheotomy mask. Once care was completed all of the staff except the ADON left the room. At 6:30 p.m., when exiting the room a large amount of mucus was noted inside of the outer cannula of the tracheotomy. The ADON was asked to lift the sheet to allow observation of the nail beds. Resident #27's nail beds were blue/gray in color and the fingers were mostly blue in color. Resident #27 was also noted to be experiencing a violent cough. The inner lumen of the oxygen tubing was noted to be completely obstructed with mucus. At 6:42 p.m., RN #8 was requested to return to the room with a biox (to test blood oxygen levels), Resident #27's biox was 84%. At 6:49 p.m., RN #8 brought suction equipment to room. Resident #27 observed coughing and gagging. At 6:52 p.m., Sterile technique was broken by RN #8 when sterile gloves were not donned with proper technique. At 6:54 p.m., Resident #27's biox is 87%, oral mucus secretions visualized, Resident #27 was observed gagging.		*those residents having the potential to be affected by the same deficient practice is*:The facility has no other residents having the potential to be affected as Resident #27 is the only resident receiving tracheostomy care. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Licensed nursing staff has been in-serviced related to tracheostomy care including competency testing with return demonstration. The Staff Development Coordinator has and will continue to observe the staff providing tracheostomy care and suctioning. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with trach care. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	At 6:57 p.m., RN #8 began suctioning but broke sterile technique when the tip of the suction tubing touched the resident's sheet, the ADON left to retrieve more equipment. The biox was 86%, mucus was observed gurgling from resident's mouth. At 7:05 p.m., The ADON was unsure of what equipment to retrieve, returns for assistance from RN #8. At 7:11 p.m., Suction equipment was brought to Resident #27's room. The resident was coughing violently, gagging, and flailing forward in bed. Biox was 89%. RN #8 indicated that he does not know this man, and he had only been on this floor for a couple of weeks. RN #8 was observed completing tracheotomy suctioning on Resident #27. RN #8 failed to dip the suction catheter into sterile water before use to check for functioning equipment and lubricate the suction catheter before beginning the procedure. RN #8 then suctioned while inserting the catheter into the tracheotomy. Suctioning was longer than 10 seconds and not intermittent. RN #8 did not wait for thirty seconds between suctioning episodes. At 7:13 p.m., Biox up to 89%, DON now to resident's room. Requested different biox to compare results. At 7:18 p.m., Different biox brought to room, Resident #27's biox was then 93%. Resident was then cleaned and			

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	repositioned in bed. A review of the "Comprehensive Care Plan Report," dated 4/5/11, indicated that, "...Problem...At risk for respiratory distress...Goal...Will have no or minimal Respiratory Distress...Approach...Oxygen as ordered, monitor & report s/sx (signs and symptoms) of shortness of breath, labored breathing and/or cyanosis (lack of oxygen), measure oxygen saturation as ordered, Lung assessment as ordered and prn (as needed)...suction as needed...Keep Physician and Family informed as needed...." The "Treatment Record" for May of 2011 stated, "...Oxygen to trach (tracheotomy) mask to maintain oxygen saturation 90% or greater...." The "Medication Record" dated May 2011 stated, "...May suction oral cavity as needed...." The "Medication Record" dated May 2011 stated, "...May suction trach prn (as needed) for increase secretions...." The "Medication Record" dated May 2011 stated, "...O2 (oxygen) to trach to keep O2 saturation greater than 90%...." On 5/17/11 at 7 p.m., RN #8 verified that Resident #27 experienced a decline in			

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	respiratory function on 5/16/11 from 6:11 p.m. until 7:18 p.m. RN #8 indicated a respiratory assessment was not completed prior to suctioning or immediately after this incident by staff to determine lung function/sounds. RN #8 also indicated the physician should have been notified. The policy titled, "Comprehensive Assessment" dated 3/05/08 was reviewed on 5/24/11 at 2:30 p.m. stated, "...Definition- Assessment Data- Resident data collected so that an analysis/evaluation of the resident's physical and mental condition or abilities may be determined by the appropriate discipline. Data is documented on assessment forms. Data may include, but is not limited to: Vital signs...Resident changes...Observation of symptoms...Pulse oximetry...Response to treatment...Effectiveness of treatment ...Oral status...." On The policy titled, "Endotracheal Care & Suctioning" dated 10/31/07 was reviewed on 5/24/11 at 4:15 p.m. stated, "...Rationale: Suctioning of the resident's airway removes increased secretions and prevents airway obstruction and aspiration...Procedure...4. wash hands. 5. Open suction catheter package. 6. Put on goggles and sterile gloves and remove suction catheter. 7. With the un-sterile			

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	hand, disconnect the resident from the aerosol or oxygen. 8. Gently pass the suction catheter down the endotracheal tube until resistance is met then withdraw the catheter slightly. 9. Apply suction while removing the catheter. 10. Re-oxygenate the resident...11. Repeat steps 8-10 until all secretions have been removed or up to the resident's tolerance of the procedure...Assessment of Outcome...12. Determine if suctioning has been successful by one or more of the following: a. Removal of secretions; b. Improvement of breath sounds...e. clearing of cough...13. When completed, place resident back on the aerosol or oxygen...Documentation of Guidelines-...2...a. Respiratory status...3...a. Date and time of physician notification...4. Notification of family member/responsible party...." 3.1-47(a)(5)			
F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 3 of 12 residents observed receiving medications. Three errors in medication administration were observed during 40	F0332	**F-332** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been*	06/23/2011

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	opportunities for error. This resulted in a medication error rate of 7.5%. Residents: # 72, # 80, # 95 Findings include: 1. The clinical record for Resident # 80 was reviewed on 5/16/11 at 10:45 A.M. A Physician Order, dated 2/5/11, indicated, "...Glucometers twice daily...Sliding Scale. If blood sugar 60-150=0 units, 151-200=4 units, 201-250=8 units, 251-300=12 units, 301-350=14 units, 351-400=16 units, Call MD if blood sugar less than 60 or greater than 350...." During first medication pass on 5/16/11 at 4:20 P.M., LPN # 17 performed an Accu Check which was 326. She drew up Humalog insulin 16 units. She entered Resident # 80's room in preparation to give the insulin and was stopped just prior to the injection being given. LPN # 17 indicated the correct sliding scale dose was 14 units. 2. The clinical record for Resident # 95 was reviewed on 5/20/11 at 2:15 P.M. A Physician Order, dated 5/16/11,		*affected by the deficient practice was*:LPN #17 received immediate re-education related to sliding scale insulin administration for resident #80. Resident #95"s physician was notified regarding the medication variance related to the Folic Acid. No new orders were received and no negative outcome related to this variance. Pharmacy was immediately notified regarding the dosage discrepancy of the Ferrous Gluconate for resident #72. Resident #72's physician was made aware and the medication order was clarified. Resident #72 had no negative outcome related to the Ferrous Gluconate dosage discrepancy. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:All other facility residents have the potential to be affected by this practice. Pharmacy and Nursing Administration checked all medication carts and medication administration records to ensure that medication orders match medications available. The facility created a blood sugar/insulin binder for easy monitoring, correct administration, and documentation of glucometer results, routine insulin, and sliding scale coverage. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Licensed nursing staff has	

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "...Folic Acid (supplement) 0.4 mg, 2 po (orally) daily..." During second medication on 5/18/11 at 9:55 A.M., LPN # 19 gave Folic Acid 0.4 mg - 1 pill. LPN # 19 indicated that she should have given two Folic Acid pills instead of one. 3. The clinical record for Resident # 72 was reviewed on 5/18/11 at 2:00 P.M. A Physician Order, dated 11/24/10, indicated, "...Ferrous Gluconate (iron) 325 mg..." During first medication pass on 5/17/11 at 9:00 A.M., LPN # 18 gave Ferrous Gluconate 324 mg. Interview on 5/18/11 at 4:40 P.M., the DON (Director of Nursing) indicated the pharmacy was unsure why they sent Ferrous Gluconate 324 mg (milligrams) instead of the ordered 325 mg dose. A facility policy titled "Medication Administration", revised 10/31/10, indicated, "...Prepare the medication using the five right of medication administration:...Right medication name and strength...Read the medication order(s), and again compare with the		been re-serviced on double checking the dosage when writing the medication orders, the five rights of medication administration and following the sliding insulin orders regarding documentation of the amount of insulin given. Licensed staff has been re-inserviced on the new binders put into place for monitoring and documenting blood sugars/insulins. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with checking medication dosage against the physician orders and following sliding scale insulins and documenting what was given. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

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	prescription label(s)...." 3.1-25(b)(9) 3.1-48(c)(1)			
F0353 SS=E	The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, interview, and record review, the facility failed to provide sufficient staffing to prevent a fall with a fracture (Resident #40) and numerous resident to resident altercations (Resident #45, #58, #68) for 2 of 2 residents in the sample of 19 and 2 of 2 residents in the supplemental sample of 30 reviewed for lack of supervision. Findings include:	F0353	**F-353** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The facility can not ascertain that additional staff would have prevented resident #40's fall as	06/23/2011

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	1. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, she indicated 12 of the 15 residents residing on the unit were incontinent and needed assistance for toileting. She further indicated Resident #40 had sustained an irreparable fractured right hip from a recent fall on the unit. A "Resident Event Report Worksheet," dated 5/3/11, indicated, "...Event Nature: Fall with significant injury...Event Adverse effect: Fracture R (right) hip...Pain R hip...Res (Resident) sitting in lounge area on alz (Alzheimer) unit...." The report indicated Resident #40 was left unsupervised in the central living area of the dementia unit. "QMA (Qualified Medication Aide) in a room with another res. and nurse in office on phone. Res. disengaged personal alarm and stood up to amb (ambulate). Nurse saw this and tried to get to res., but she fell on R side before he could reach her." LPN #3 indicated in an interview on 5/17/11 at 3:00 P.M., Resident #40 fell next to the small sofa. "There were two staff on duty, but they were busy at the time of the fall." During observation of the dementia unit		the staff were in direct observation of the resident at the time of the fall. Resident's #46, #47, #49 and #95 had no affects from the observations made during the course of the survey. Resident #38 and #45 have not had additional incidents since the reported incidents. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No other residents were affected by the deficient practice, however additional staff has been allocated to the Reflections/Dementia unit to assist with supervision to include monitoring of resident behavior, responding to alarms and ensuring residents are prepared for meal times. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The executive director and director of nursing have been in-serviced related to ensuring that appropriate staffing levels and supervision is present to meet the needs of the residents. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with the placement and presence of additional staff resources. The Executive Director or designee will complete monthly for the first quarter and quarterly thereafter	

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	on 5/16/11 at 8:00 A.M., the nurse's station was observed to have a windowed wall separating the nurse from Resident #40 at the time of the fall. On 5/18/11 at 5:20 P.M., the Social Service/Director was observed to be in Resident #47's room providing incontinence care and CNA #27 was observed in Resident #49's room providing incontinence care. Resident #95 was observed sitting on a small sofa in the central living area of the dementia unit. Resident #95 stood up and his mobility alarm sounded. Both staff on the unit failed to hear his alarm sounding because they were each in another resident's room providing care. No one responded to Resident #95. His alarm sounded for a full five minutes before the Social Service/Director appeared. She was observed assisting Resident #47 ambulate to the dining room. She stated, "Is that (Resident #95)? I can't help him until I get (Resident #47) down." Immediately after she made the statement, Resident #43 was observed attempting to exit the unit via the East door. The door alarm sounded and CNA #27 responded and re-directed Resident #43 away from the door. At 5:54 P.M. (5/18/11), the Social Service/Director asked QMA #31, who had arrived on the unit to pass dinner		with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	trays, if anyone had gotten Resident # 46 up for dinner. The D.O.N. and Corporate Nurse #32, who also arrived on the unit to help pass dinner trays, indicated they would get Resident #46 up and bring her down for dinner. Resident #46 was assisted to the dining room at 6:05 P.M. Her tablemate's were already served their meals and were observed eating them. Review of staff schedules for the dementia unit indicated there is one nurse and one CNA scheduled for the 7:00 A.M. -3:00 P.M. and the 3:00 P.M.-11:00 P.M. shift. The 11:00-7:00 A.M. shift has either one nurse or one CNA scheduled. On dates when the CNA is scheduled (11:00 P.M.-7:00 A.M.), the nurse from the North unit is on call for emergency needs that arise on the dementia unit. A facility policy titled "Sufficient Nursing Staff," revised 4/28/10, indicated, "Rationale: Each (Name) nursing center has sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident...Center Quality of Care: ...Determine the level and mix of staff needs to be adjusted to address specific quality concerns...."			

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	2. Review of the Resident to Resident incidents of abuse, dated 7/9/10, indicated, Date of Alleged incident - 7/3/10 at 12:30 P.M., Resident # 58 was slapped on the right side of her face by another resident who was supposed to be on 1 on 1 supervision at the time, however, the nurse providing 1 on 1 was on the telephone at the time of the incident. 3. Review of the Resident to Resident incidents of abuse, dated 8/8/10, indicated, Date of Alleged incident - 8/7/10, untimed, RN # 38 was walking down the south hallway towards the nurses station when she saw Resident # 68 right leg being held down by another resident with his right hand as he hit her with his left hand. 4. Review of the Resident to Resident incidents of abuse, dated 10/23/10, indicated, Date of Alleged incident - 12/20/10, untimed, Resident # 45 suffered a fall and bruise to the right forearm. The nurse on the unit was in the lounge area when she heard Resident # 45 yell, "Get out of here". As she started towards the room, she heard the Resident say, "Stop pushing me, you're going to make me fall." When the nurse entered the room, she saw Resident # 45 on the floor of her room with a male resident standing over	F0353	**F-353** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The facility can not ascertain that additional staff would have prevented resident #40's fall as the staff were in direct observation of the resident at the time of the fall. Resident's #46, #47, #49 and #95 had no affects from the observations made during the course of the survey. Resident #38 and #45 have not had additional incidents since the reported incidents. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No other residents were affected by the deficient practice, however additional staff has been allocated to the Reflections/Dementia unit to assist with supervision to include monitoring of resident behavior, responding to alarms and ensuring residents are prepared for meal times. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The executive director and director of nursing have been in-serviced related to ensuring that appropriate staffing levels	06/23/2011

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	her. 3.1-45(a)(1) 3.1-45(a)(2)		and supervision is present to meet the needs of the residents. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with the placement and presence of additional staff resources. The Executive Director or designee will complete monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview, and record review, the facility failed to ensure the required no-salt beef base was available for the pureed recipe. This deficient practice had the potential to affect 5 of 6 residents on a no-added salt puree diet. Findings include: During observation of the facility kitchen on 5/16/11 at 3:40 P.M., Dietary Cook #33 was observed preparing the puree meat for the evening meal. He placed 12 pieces of processed country fried beef	F0363	**F-363** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:No residents were found to be affected by this practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No other residents were affected by this practice. *The measures put into place and a systemic change made to*	06/23/2011

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	patties into the food processor. The recipe called for sodium-free beef base. Cook #33 indicated the only beef base available in the facility had sodium in it. The Dietary Manager left the facility to purchase sodium-free beef base, but returned with low-sodium beef base. Upon return and in interview, The Dietary Manager indicated there was no sodium-free beef base available in the supermarket. The low-sodium beef base contained 45 milligrams of sodium per serving. The Dietary Manager indicated she understood the necessity of sodium-free beef base because the processed beef already contained plenty of sodium. She further indicated she would order sodium-free beef base for future use. Review of a dietary report, which listed residents with special diet needs, provided by the Dietary Supervisor on 5/24/11, indicated six residents received puree diets and five of those six were on a no-added salt diet. 3.1-20(a)		*ensure the deficient practice does not recur is*: All facility recipes were reviewed to ensure that appropriate ingredients are available to prepare foods according to recipe. Dietary cooks have been in-serviced to adherence to menus and recipes. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with all menus and recipes are being followed. The Nutritional Service Director or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure proper sanitation of the facility kitchen, two refrigerators on the North Unit, and a microwave in the South Dining Room were kept clean and sanitary to promote safe food handling for 91 of 94 residents who eat in the facility. Findings include: A. During observation of the facility kitchen on 5/16/11 at 6:30 A.M., while accompanied by Dietary Cook #34, the following was observed: 1. The kitchen staff handwashing sink was soiled with a build-up of a beige and red dust. 2. A stainless steel plate warmer was laden with a sticky brown substance. 3. A cooked ham loaf was observed resting on top of a box of raw hamburger in the walk-in cooler. 4. Four trays of uncovered cookies in the walk-in cooler. 5. Bacon with an expiration date of 5/09/11 in the walk-in cooler. 6. A food delivery man entered the walk-in cooler without a hair restraint. 7. The facility beautician entered the main	F0371	**F371** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:The kitchen staff hand washing sink has been cleaned. The stainless steel plate warmer has also been cleaned. The cooked ham loaf and the uncovered cookies were discarded immediately. The bacon was discarded immediately. The delivery man has been provided a hair restraint and made aware of necessary adherence to this policy. The beautician has been re-inserviced to not enter the kitchen without use of a hair restraint. Cook 34 has been re-inserviced on proper glove use while in the kitchen. The kitchen refrigerator was cleaned immediately and the two cartons of tomato juice were discarded. All staff has been in-serviced on not entering the kitchen without a hair restraint. The can opener point was cleaned immediately. The four cartons of buttermilk were	06/23/2011

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	area of the kitchen without a hair restraint. 8. Cook #34 moved from task to task touching several different surfaces, including soiled dishes in the sink, items in the walk-in cooler and storage room, without removing gloves and washing hands prior to handling biscuits. 9. A refrigerator located in the kitchen was heavily soiled inside with dried spillage and food particles. Two cartons of tomato juice expired 2/28/11 were inside the refrigerator. The outside was heavily soiled with a build-up greasy hand prints and dried food. During observation of the kitchen on 5/16/11 at 10:20 A.M., the following was observed: 1. CNA #35 entered the kitchen without a hair restraint. 2. The can opener point was laden with a build-up of dried food. 3. Four cartons of buttermilk, dated 4/28/11 with a use by 5/04/11 date, were in the walk-in cooler. 4. A dented can of Sauerkraut on storage shelf. 5. Shelves in the dry food storage area were laden with a build-up of dust. 6. A food tray cart was heavily soiled with dust and dried food particles. 7. Knobs on the steam table were laden with a build-up of dried food substance. 8. Dried food particles were laden on the		discarded immediately. The dented can of Sauerkraut was discarded immediately. The shelves in the dry food storage area were cleaned immediately. The food tray cart was cleaned immediately. The knobs on the steam table were cleaned immediately. The lids to the plate warmer were cleaned immediately. The four stainless steel cookie sheets were cleaned and dried immediately. The five plates were cleaned immediately and the plate that was chipped was discarded. The two juice pitchers and five sippy cups were cleaned immediately. The two dish carts were cleaned immediately. The kitchen staff has been in-serviced on the proper technique to maintain the proper temperature regarding the dish machine for the first batch of dishes. The hands free hand washing sink has been changed to a non hands free device. The pots and pans were rewashed and a heater for the triple sink has been ordered to help maintain proper temperatures. The refrigerator in the Occupational Therapy room was cleaned immediately. The refrigerator located near the linen room was cleaned immediately. The microwave in the south dining room was cleaned immediately. *The corrective action taken for those residents having the potential to be affected by the same deficient practice*	

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	lids of the plate warmer. 9. four stainless steel cookie sheets were stored with moisture between them. 10. Five plates were stored with dried food on them. One plate was chipped. 11. Two juice pitchers and five sippy cups were stored with clean dishes while they were still laden with remnants of beverages and cocoa. 12. Two dish carts were heavily soiled with dried spillage and food particles. During observation of the kitchen on 5/17/11 at 9:00 A.M., the following was observed: 1. The automatic dishwasher had to be run four times before temperature was 150 degrees (specifications for the machine). 2. The handwashing sink (auto) had to be activated 15 times before water was hot for handwashing. 3. The triple manual dishwashing sink had a temperature of 98 degrees F. in the wash sink and 92 degrees F. in the rinse sink. Dietary aide #36 was observed washing pots and pans. During interview with Dietary Aide #37 on 5/17/11 at 9:05 A.M., she indicated she was not aware she had to run the first batch of soiled dishes through the automatic dishwasher several times until the temperature came up to 150 degrees F.		*is*:No other residents were affected by the practice. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Dietary staff has been re-inserviced regarding kitchen sanitation. Facility staff has been in-serviced regarding proper sanitations of refrigerators and microwaves. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with kitchen sanitation and proper sanitation of refrigerators and microwaves. The Nutritional Service Director or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	The Dietary Manager indicated in an interview on 5/17/11 at 9:08 A.M., that she had inserviced all dietary staff on the importance of ensuring the dishwasher was the correct temperature. "I will inservice all of them (staff) again." B. During the environmental tour of the facility on 5/20/2011 at 2:30 p.m., accompanied by the Maintenance Director # 41 and the Housekeeping Director # 42 the following was observed: 1. The refrigerator in the Occupational Therapy room was observed to be soiled with dust and dirt debris. 2. The refrigerator located near the linen room was observed to have a spilled tan substance in the bottom drawer. The shelves in the refrigerator were soiled with food debris. 3. The microwave oven in the south dining room was observed to be soiled with dried food debris. 3.1-21(l)(3)			

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to ensure the ordered medications were available for 1 of 12 residents observed for medications in a sample of 19 and that expired medications were removed from the medications carts in a timely manner in 3 of 5 medication carts. Resident # 1, # 56, # 72, and # 85 Findings include: 1. The clinical record for Resident # 72 was reviewed on 5/18/11 at 2:00 P.M A Physician Order, dated 11/24/10,	F0425	**F-425** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:Resident #72's medication order for ferrous gluconate was clarified by the resident's physician to read 324 mg po qd. Medications were re-ordered and received by the pharmacy for residents #1, #56, #85 and #66. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No residents were affected by this practice. Pharmacy has audited	06/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

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	indicated, "...Ferrous Gluconate (iron) 325 mg..." During first medication pass on 5/17/11 at 9:00 A.M., LPN # 18 was observed to give Resident # 72 Ferrous Gluconate 324 mg. Interview on 5/18/11 at 4:40 P.M., the DON (Director of Nursing) indicated the pharmacy was unsure why they sent Ferrous Gluconate 324 mg (milligrams) instead of the ordered 325 mg dose. 2. During inspection of the medication carts, the following was observed: South B medication cart on 5/18/11 at 3:00 p.m. Resident # 56: One bottle of Timolol 0.5 % eye drops, fill date 1/17/11, open date 2/2/11, one bottle of Lotemax 0.5 % eye drops, fill date 12/11/10, open date 2/2/11. Resident # 85: One bottle of Flunisolide NS (nasal spray) 0.025 %, fill date 12/1/10, no open date, one Advair 500/50 (asthma medication), fill date 3/22/11, open date 3/30/11, discard date 4/28/11. 3. South A Medication Cart on 5/18/11 at 3:18 P.M.:		all medication carts to ensure no expired meds are present and all ordered medications are available for administration. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: All licensed nursing staff has been in-serviced on proper transcription of medication orders and ensuring no expired meds are present and all expired meds are replaced. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates transcription of physician orders and routine med cart review to ensure no expired medications are present. The Director of Nursing or designee will complete weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	Resident # 66: One bottle of Nitroglycerin (medication used to help prevent a heart attack) 0.4 mg (milligram), fill date 9/10/09, expiration date 3/2010. 4. North A Medication Cart on 5/18/11 at 4:55 P.M.: Resident # 1: One bottle Genteal gel drops (eye drops), fill date 12/13/10, open date 1/31/11. An "Executive Summary of Consultant Pharmacist's Medication Regimen Review", indicated the medication carts were last inspected 5/9/11. A facility policy titled, "Medication Administration", revised 10/31/10, indicated, "...Remove and dispose of...outdated..." A facility policy titled "Medication Administration", revised 10/31/10, indicated, "...Prepare the medication using the five right of medication administration:...Right medication name and strength...Read the medication order(s), and again compare with the prescription label(s)...." 3.1-25(a) 3.1-25(o)			

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F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were labeled according to accepted standards for 3 of 5 medication carts. Nitroglycerin tablets were found with no identifying information and	F0431	**F-431** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been*	06/23/2011

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	medications were found with no first open date. This deficient practice affected 3 of 94 residents. (Resident # 83, Resident # 8) Findings include: During inspection of the medication carts, the following was observed: 1. Reflections Medication Cart: One bottle of Nitroglycerin 0.4 mg, no patient identification label present. Interview with the DON (Director of Nursing) on 5/18/11 at 3:35 P.M., she indicated that the pharmacy checks the medication carts monthly. On 5/18/11 at 5:40 P.M., the DON indicated she was unable to verify who the bottle of Nitroglycerin belonged to because it was not labeled appropriately. An "Executive Summary of Consultant Pharmacist's Medication Regimen Review", indicated the medication carts were last inspected 5/9/11. 2. South B Medication Cart: Resident # 83: One Advair 250/50, fill date 4/6/11, no open date.		*affected by the deficient practice was*:The medications for residents #8 and #83 were reordered and received by the pharmacy. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents were affected by this practice. Pharmacy has audited all medication carts to ensure appropriate labeling and dating of applicable medications when initially opened. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Licensed nursing staff has been in-serviced on ensuring appropriate medication labeling and dating of applicable meds when initially opened. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with labeling and date opened as indicated. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	3. North A Medication Cart on 5/18/11 at 4:55 P.M.: Resident # 8: One bottle Dorzolamide HCl 2 % eye drops, fill date 2/21/11, no open date. A "Medications with Special Expiration Date Requirements" sheet, dated 06/10, indicated, "...Advair...30 days after removal from foil-pack...Eye drops...60 days after opening...Nitroglycerin...should be discarded 12 months after opening...Guidelines...The date of opening should be noted on the container/vial.... 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented related to lack of handwashing for 3 of 3 residents	F0441	**F-441** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken*	06/23/2011

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	(Residents #40, #11, #27) observed for care, open/expired respiratory equipment at the bedside (Resident #27)for 1 of 1 residents reviewed for respiratory treatment, a clinically compromised resident admitted to a C-difficile resident's room (Resident #87), and improper sanitation of a glucometer used for 1 of 2 diabetics (Resident #80) in the sample of 19. Findings include: 1. Resident #40's clinical record was reviewed on 5/16/11 at 2:35 P.M., and indicated diagnoses of, but not limited to: history of sacral/pelvic fracture, osteoporosis, macular degeneration, senile dementia, and osteoarthritis of the hips. CNA #15 was observed providing incontinence care to Resident #40 on 5/18/11 at 11:35 A.M. After completing the care, she placed the soiled linen into a bag, removed her gloves, and left the room with the bag. She did not wash her hands prior to exiting the resident's room.		*for the residents found to have been affected by the deficient practice was*:There was no negative outcome to resident #40 due to the C.N.A. not washing her hands after removing her gloves. The ambu-bag was replaced for resident #27. R.N. 8 and the ADON were immediately re-inserviced on proper use of gloves. Resident #27 had no negative outcome related to this practice. There was no negative outcome to resident #11 relative to this practice. Resident #87's roommate is currently free from C-difficile infection and is an appropriate roommate per facility policy. L.P.N. #17 was immediately re-educated on the proper sanitation/disinfection of the glucometer per facility policy for resident #80. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:All residents have the potential to be affected by these practices. All staff has been in-serviced on facility policy for hand washing and proper glove use. Licensed staff has been re-inserviced on disinfection/sanitation of the glucometer per facility policy and placement of residents with infectious processes. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Nursing Administration will conduct an observational audit of hand washing, glove	

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	2. Resident #27's record was reviewed on 5-16-2011 at 10:15 a.m. Resident #27's diagnoses include, but were not limited to, brain injury, quadriplegia, dysphagia, and vegetative state. On 5/16/11 at 6:30 p.m., observed ambu-bag hanging from IV pole next to Resident #27's bed. The bag was hanging open. The open dated was "12/4 @ (at) 2100 (9:00 p.m.)...discard 12/5 @ 2100."		usage, and glucometer cleaning across all three shifts to ensure adherence to facility policy and procedure. ADNS, or designee, will review any residents with infectious processes, ongoing, to ensure appropriate placement. Any identified concerns will be immediately corrected with the involved employee. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with hand washing, wearing gloves, glucometer cleaning, and review of residents with infectious processes. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	The ambu-bag was sticky to the touch. On 5/16/11 at 6:49 p.m., RN #8 was observed while donning sterile gloves. RN #8 touched the outside of the sterile gloves with bare hands and was unsure if sterile technique was broken. On 5/16/11 at 6:57 p.m., the ADON was observed leaving Resident #27's room during a treatment with gloves on. The ADON returned within minutes with gloves still on. The ADON then returned to the bedside and continued to assist RN #8 with the treatment. 3. Resident # 11's record was reviewed on 5/17/11 at 3:20 p.m. The Resident's record indicated diagnoses of, but not limited to; paralysis of the lower limbs, pressure ulcers, depression, and diabetes. An observation was made of dressing changes to Resident # 11's numerous wounds on 5/18/11 at 9:50 a.m. RN #10 and the ADON was changing the numerous dressings. The Resident's open wounds on both of his feet, RN #10 applied Sea Cleanse spray to moisten the old dressings of Acticote. RN #10 removed them and placed the soiled dressings in a small red bag at the foot of the bed. RN # 10			

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	removed her soiled gloves and immediately put on another pair without washing her hands prior to donning clean gloves. RN # 10 repeated the same procedure on the open wounds on the resident's buttocks, the open wound on the Resident's knee and thigh. After RN # 10 removed the soiled dressings and placed them in the red bags, she immediately put on clean gloves without washing her hands. Three squares of soiled Acticote dressings were observed sitting on the residents counter by his sink and one was observed on the resident's floor. RN #10 was observed to grab the soiled squares of Acticote dressings with her bare hands and place them in the red trash bags. 4. The clinical record for Resident # 87 reviewed on 5/19/11 at 1:45 P.M., indicated diagnoses of, but not limited to, hepatitis C, spinal cord disease, paraplegia, and chronic pain. Review of a "Physician Emergency Department Note", dated 2/16/11, fax stamp date 2/23/11, indicated, "...Hepatitis C..."			

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	155474	A. BUILDING 00 B. WING	05/24/2011

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A "History and Physical", dated 2/26/11, performed by (Name) M.D., indicated, "Hepatitis C...right now he will be on universal precautions..."

Resident # 87 was admitted to a semi private room on 2/24/11 with a diagnosis of Hepatitis C. He was admitted into this room with a resident who had an active case of Clostridium Difficile (C diff).

Interview on 5/19/11 at 4:00 P.M., the ADON indicated that a resident with a diagnosis of C diff would warrant isolation and that she would not place a resident who is immunocompromised in the same room.

On 5/19/11 at 4:10 P.M., RN # 20 indicated a resident who is severely compromised would not be appropriate to be placed in the same room with someone who has C diff. She further indicated a diagnosis of C diff would warrant isolation.

A facility policy titled "...Hepatitis C," revised 10/31/06, indicated, "...approximately 50 % develop chronic infections. This subset of residents remains contagious and is at risk for cirrhosis, cancer and other complications....Degree of immunity

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	following infection is not known..." A facility policy titled "Clostridium Difficile...,", revised 05/05/11, indicated, "Clostridium difficile...Interventions are put into place to prevent the spread of C-Dif....Those that are high risk for C. difficile infection include...Immunocompromising conditions...Use Contact Precautions...Place these patients in private rooms. If private rooms are not available, these patients can be placed in rooms...with other patients with C. difficile-associated disease.... 5. During first medication pass on 5/16/11 at 4:20 P.M., LPN # 17 performed an Accu Check (blood sugar test) on Resident # 80. After completion of the test, she carried the Accu Check monitor out to the medication cart in the hallway and placed it in a black pouch on the top of the cart. At 4:40 P.M., LPN # 17 prepared to do a Accu Check on the next resident. She gathered her supplies from the medication cart including the Accu Check monitor and carried the supplies into the resident's room without sanitation of the monitor. Once in the room, LPN # 17 was instructed to return to the medication cart in the hall. She then cleaned the monitor			

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	with a 70 % Alcohol Pad. Interview with LPN # 17 on 5/16/11 at 4:50 P.M., she indicated the policy is to clean the Accu Check monitors with Alcohol Pads. A facility policy titled, "SureStepFlexx Blood Glucose...Cleaning," revised 10/31/10, indicated, "...Wash inside cover...using a 10 % bleach solution moistened wipe....Clean the outside of the meter with a 10 % bleach solution moistened wipes in-between each resident and as needed...." 3.1-18(b)(2) 3.1-18(l)			
F0465 SS=D	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations and interview, the facility failed to ensure the facility kitchen was kept clean and sanitary for dietary staff and 91 of 94 residents residing in the facility. Findings include: During observation of the kitchen on 5/16/11 at 10:20 A.M., the following was observed:	F0465	**F-465** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:No residents were found to be affected by this practice. The floors in the dry food storage area were cleaned immediately. The	06/23/2011

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BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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	1. Floors in the dry food storage area had a build-up of dirt under the bottom shelves. 2. The ventilation filters and sprinkler heads heavily laden with grease and dust. 3. The large range had a build-up of grease/dust on the back of it, including the floor behind and beneath it. 4. A build-up of dust on the sprinkler heads on the kitchen ceiling. 5. A ceiling heater was heavily laden with dust. 6. A sippy cup was back in a corner on the floor under the dishwashing sink. 7. Walls in the kitchen and in the food serving area just outside the kitchen were laden with dried drippings. During interview with Cook #34 on 5/16/11 at 10:30 A.M., she indicated the kitchen was thoroughly cleaned the week prior. 3.1-19(f)		sprinkler heads were cleaned immediately and the facility purchased new ventilation filters. The range along with the floor around the range was cleaned immediately. The sprinkler heads in the kitchen were cleaned immediately. The ceiling heater was removed. The sippy cup was washed immediately. The walls in the kitchen and outside the kitchen were cleaned immediately. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:No other residents were affected by this practice. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Dietary staff has been re-inserviced regarding kitchen sanitation. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with maintaining a clean and safe environment. The Nutritional Service Director or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review, observation and interview, the facility failed to ensure resident records were complete and legible for 3 of 3 residents reviewed for proper documentation in a sample of 19. (Residents: # 11, # 3, and # 80) Findings include: 1. Resident # 11's record was reviewed on 5/17/11 at 3:20 p.m. The Resident's record indicated diagnoses of, but not limited to; paralysis of the lower limbs, pressure ulcers, depression, and diabetes. Resident # 11's MAR (medication administration record) indicated he received insulin by way of sliding scale. A physician's order, dated 4/8/11, indicated "Novolog Sliding Scale before meals. Novolog 100u/ ml (milliter), < 0-100 = 20 units, 101-150 = 25 units, 151-200 = 33 units, 201- 250 = 35	F0514	**F-514** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:All glucometer checks were completed as ordered for resident #11 and the correct amount of insulin was administered per sliding scale.Resident #3 does not have physician for glucometer testing at 12pm. and 6pm. This resident does receive sliding scale insulin coverage for glucometer testing at 6am and 4pm. Per review of resident 3's MAR, the correct amount on insulin was administered for glucometer results on 3/21/11, 3/24/11, and 3/25/11. Resident 3' s physician was informed of the medication variance related to Diltiazem and no new orders were received. The physician was also notified of oxygen	06/23/2011

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	units..." The MAR dated May 2011, indicated on 5/6/11 the resident's blood glucose was 151. The MAR lacked documentation to indicate if the Resident received his sliding scale insulin of 33 units. The MAR lacked documentation on 5/4/11 and 5/10/11 of a glucose result, or any insulin administered. Both dates were left blank. During an interview with LPN # 3 on 5/17/11 at 3:30 p.m., regarding the blanks in the MAR, she looked at the MAR and indicated she was not the nurse who left the blanks and indicated the documentation should have been completed.		saturation levels not obtained as ordered on four occasions in the month of May and no new orders were received.The physician has been notified for resident #80 relative to elevated blood sugars with no new orders received. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:A facility wide audit was conducted to identify those residents requiring sliding scale insulin. A facility wide medication administration record and treatment administration record audit for the month of June has been conducted to review compliance with all medications requiring specialized parameters. Any variances to prescribed treatment regime will be reported to the physician for further review and recommendation. The facility created a blood sugar/insulin binder for easy monitoring of correct administration, and documentation of glucometer results, routine insulin, and sliding scale coverage. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Licensed nursing staff has been in-serviced on the usage of the new blood sugar/insulin binders which will help monitor correct administration, and documentation of glucometer results, routine insulin, and sliding scale coverage. Licensed staff will be re-inserviced on following	

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	`2. Resident #3's record was reviewed on 5-19-2011 at 2:00 p.m. Resident #3's diagnoses include, but were not limited to, Diabetes Mellitus, dementia, history of a right femur fracture, and depression. The "Medication Record" for the month of March 2011 stated, "...Sliding scale, if blood sugar 0-150= 0 units, 151-200= 3 units, 201-250= 6 units, 251-300= 9 units, 301-350= 12 units, 351-400= 14 units, call MD if blood sugar less than 60 or greater than 400...." The "Medication Record" on 3/21/11 at		physician orders related to obtaining oxygen saturation levels and adherence to ordered directives/parameters for specified medications. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with following insulin orders and oxygen saturation levels, and medications requiring additional monitoring. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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	6:00 p.m., Resident #3's blood sugar was not taken and no coverage was given. The "Medication Record" on 3/24/11 at 6:00 p.m., Resident #3's blood sugar was not taken and no coverage was given. The "Medication Record" on 3/25/11 at 12:00 p.m. Resident #3's blood sugar was not taken and no coverage was given. The "Medication Record" for the month of April 2011 stated, "...Diltiazem (a medication used to treat an irregular heart rhythm) 60 mg. Give 1 tablet by mouth every 6 hours. Dx (diagnosis): AFIB (atrial fibrillation) *Hold if SBP (systolic blood pressure) <90...." The "Medication Record" indicated that Resident #3's blood pressure was not taken twice during the month of April and no medication was administered. The "Medication Record" for the month of May 2011 stated, "...Oxygen per nasal cannula to keep oxygen saturation above 90% may wean as tolerated...." The "Medication Record" indicated a biox (blood oxygen level) was not taken 4 times during the month of May 2011. An interview was completed on 5/19/2011			

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at 2:30 p.m., with RN #3. RN #3 indicated that if the blood sugar or amount of insulin given was not documented in the chart she would assume it was not done. There is no other book they use to put documentation.

3. The clinical record for Resident # 80 reviewed on 5/16/11 at 10:45 A.M., indicated diagnoses of, but not limited to, diabetes mellitus, acute kidney failure, and peripheral neuropathy.

A Physician Order, dated 2/5/11, indicated, "...Glucometers twice daily...Sliding Scale. If blood sugar 60-150=0 units, 151-200=4 units, 201-250=8 units, 251-300=12 units, 301-350=14 units, 351-400=16 units, Call MD if blood sugar less than 60 or greater than 350...."

Review of the February 2011, MAR (Medication Administration Record) indicated Residents # 80's blood sugars as follows:

2/12/11 at 4:00 P.M. - 296. The clinical record lacked documentation of coverage.

Review of the April 2011, MAR indicated blood sugars as follows:

4/12/11 at 4:00 P.M. - 243. The clinical

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	record lacked documentation of coverage. Review of the May 1 through 17, 2011, MAR indicated blood sugar on 5/17/11 at 6:00 A.M. was 178. The clinical record lacked documentation of the amount of coverage given. The February 2011, April 2011, and May 1 through 17, 2011, MAR indicated Resident # 80's record lacked clinical documentation on three occasions. Resident # 80's Care Plan, dated 5/19/11, indicated, "...Medication as ordered. See Physician's Orders..." Resident # 80's Care Plan, dated 5/19/11, indicated, "...Medication as ordered..." Interview on 5/20/11 at 9:15 A.M., the ADON (Assistant Director of Nursing) indicated she was unable to verify if the resident received coverage on the above dates. A facility policy titled "Medication Administration", revised 10/31/10, indicated, "...Document administration...of the medication...on the MAR..." 3.1-50(a)(1) 3.1-50(a)(2)			

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	155474	A. BUILDING 00 B. WING	05/24/2011

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F0516 SS=B	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation and interview, the facility failed to ensure unlicensed staff did not have access to resident records related to the Housekeeper having the key to the medical record room in his possession. This deficiency has the potential to affect any of the 94 of 94 residents whose medical records are stored in the medical record room. Findings include: During an environmental tour of the facility on 5/20/11 at 2:30 p.m., accompanied by the Maintenance Director # 41 and the Housekeeping Director # 42, an observation of the medical records room was requested. An observation was made of the Housekeeper # 42 taking a key that he had	F0516	**F-516** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*:No residents were affected by this practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: All residents of the facility have the potential to be affected, therefore, this plan of correction applies to all residents currently residing in the facility. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The lock to the medical records room has been changed. No unlicensed or uncertified staff has a key or access to the	06/23/2011

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	155474	A. BUILDING 00 B. WING	05/24/2011

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	in his possession and open the locked medical records room door. An observation was made of one resident's medical record sitting on a table. The other records were observed to be located in metal file cabinets. Three of the file drawers were not locked and able to be pulled open when checked. During an interview with the Housekeeper on 5/20/11 at 3:00 p.m., regarding having the key to the medical record room, he indicated he needed to have a key because there are times he needed to get in there. 3.1-50(d)		secured medical records office. All staff have bee re-educated relative to the necessity of safeguarding medical records. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with who has access to the medical records office. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	
F9999	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility, but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual	F9999	**F-9999** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:*The corrective action taken for the residents found to have been affected by the deficient practice was*:No residents were found to have been affected by lack of reporting of the events to ISDH.*The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:The	06/23/2011

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	occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents. This rule was not met as evidenced by: Based on interviews and record review, the facility failed to report significant injuries, which resulted in fractures, to the proper State authorities. This deficient practice affected 2 of 3 residents (Residents: #40, #58) in the sample of 19 and 1 of 1 (Resident #3) residents reviewed with significant injuries in the supplemental sample of 31. Findings include: 1. Resident #40's clinical record was reviewed on 5/16/11 at 2:35 P.M. and indicated diagnoses of, but not limited to: history of sacral/pelvic fracture, osteoporosis, macular degeneration, senile dementia, and osteoarthritis of the hips. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, she indicated Resident #40 had sustained an irreparable fractured right hip from a recent fall on the unit. Resident #40 had facial grimacing and indicated she was having pain at the time.		Event Log and event reports for the last 30 days were audited to identify if any events met the criteria for reporting to ISDH. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The facility will report all resident unusual occurrences in accordance with the Indiana State Department of Health Reportable Unusual Occurrence policy effective 01/25/2006.The Executive Director and Director of Nursing Services will be in-serviced relative to the Unusual Occurrence guidelines. *To ensure the deficient practice does not recur, the monitoring system established is*:A Performance Improvement indicator has been established which evaluates compliance with reporting reportable incidents to the Indiana State Department in accordance with the Unusual Reporting Occurrence guidelines. The Executive Director or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11	

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A "Resident Event Report Worksheet," dated 5/3/11, indicated, "...Event Nature: Fall with significant injury...Event Adverse effect: Fracture R (right) hip...Pain R hip...Res (Resident) sitting in lounge area on alz (Alzheimer) unit...." The report indicated Resident #40 was left unsupervised in the central living area of the dementia unit. "QMA (Qualified Medication Aide) in a room with another res. and nurse in office on phone. Res. disengaged personal alarm and stood up to amb (ambulate). Nurse saw this and tried to get to res., but she fell on R side before he could reach her."

LPN #3 indicated in an interview on 5/17/11 at 3:00 P.M., Resident #40 fell next to the small sofa. "There were two staff on duty, but they were busy at the time of the fall."

During observation of the dementia unit on 5/16/11 at 8:00 A.M., the nurse's station was observed to have a windowed wall separating the nurse from Resident #40 at the time of the fall.

Review of Nurse's Notes indicated the following:
"5/2/11 at 2:00 P.M.-Up with assist of one with walker to meals and BR (bathroom)...5/3/11 at 9:30 P.M.-Res. was

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	sitting in Dayroom. Disengaged her Mobility Monitor. Observed standing in Dayroom got up to go to rm (room). Res. lost bal (balance) et (and) fell to floor on R side...." 2. Resident #3's record was reviewed on 5-19-2011 at 2:00 p.m. Resident #3's diagnoses include, but were not limited to, dementia, depression, and Diabetes Mellitus. The "Resident Event Report Worksheet," dated 6/25/10 at 7:00 p.m., stated, "...had been a 2 assist (two person assist) c (with) no wt (weight) bearing prior to this. Therapist also asked for w/c (wheelchair) pedals to be removed from w/c...to try to propel w/c...Just outside the DR(dining room) door (Name) Resident #3 dropped her R (right) leg stopping the w/c, . The nurse assessed immediately + (and) R leg was at a 90 degree angle but previously only bend to 30 degree angle c brace on. X-rays 6/25 ER- Negative report. Returned to facility, kept on bedrest per dtr (daughter) request until MD (physician) sees. MD in 6/26 + had previous x-rays reread + Dr (Name) noted a compacted Fx (fracture) of the Distal Femur. Resident sent to (Name) Hospital....			

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	The "Resident Progress Notes," dated 6/27/10, (untimed), stated, "...I was in the South DR (dining room) transporting residents back to their rooms/units. (Name) Resident #3 was in the middle of South DR trying to propel herself. I was behind her...I told her I would push her. She said ok. I propelled her out into the hallway...past the doors when the w/c suddenly came to stop and she yelled out in pain. I come around to the front of the w/c and saw she had no leg lifts on her w/c. Both legs were bent at the knee in about a 90 degree sitting angle. I backed up the w/c so as to straighten her legs and asked her why she didn't have leg lifts on her w/c. She said she didn't know. Res (resident) couldn't pick up either leg/foot from floor so I could propel her forwards (sic). I turned her w/c around et (and) took her back to her unit/room. Res c/o (complained of) her leg hurt. I reported what happened to her nurse (Name). I was unaware the (Name) Resident #3 didn't have her leg lifts when I began pushing her...." The "Rehab Communication Slip" dated 6/24/10, (untimed), stated, "...Discontinue leg rests (effective 6/25/10)...." 3. The clinical record for Resident # 58 reviewed on 5/16/11 at 10:20 A.M., indicated diagnoses of, but not limited to,			

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	hip fracture, dementia with behaviors, osteoporosis, and hypothyroidism. During initial tour of the South A Hall on 5/16/11 at 6:35 A.M., LPN # 16 identified Resident # 58 as having a right hip fracture from a fall. Review of a "Resident Event Report Worksheet", dated 1/31/11, indicated "...Reported to State...No...Transferred to Hospital...Yes...Fall with significant injury...Fracture left femur..." Review of the state reportable's lacked documentation of the incident being reported as mandated. Interview on 5/18/11 at 6:30 P.M., the DON indicated she was unaware that fractures of independent residents had to be reported.			